**Patient History**

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:**\_\_\_\_\_\_\_\_\_\_

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe the current problem that brought you here. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When did your problem first begin? \_\_\_\_\_\_\_\_\_ months ago or \_\_\_\_\_\_\_\_\_ years ago.
3. Was your first episode of the problem related to a specific incident? Yes/No
4. Since that time is it: staying the same  getting worse getting better

Why or how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If pain is present rate pain on a 0-10 scale, 10 being the worst. Choose an item. Describe the nature of the pain (i.e. constant burning, intermittent ache) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe previous treatment/exercises \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Activities/events that cause or aggravate your symptoms. Check all that apply.

Sitting greater than\_\_ minutes

Walking greater than \_\_\_minutes

Standing greater than\_\_\_ minutes

Changing positions (ie.- sit to stand)

Light activity (light housework)

Vigorous activity/exercise

(run/weight lift/ jump)

Sexual activity

With cough/sneeze/straining

With laughing/yelling

With lifting/bending

With cold weather

With trigger- running water/key

in door

With nervousness/anxiety

No activity affects the problem

Other, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet/Fluid intake, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical activity, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Rate the severity of this problem from 0-10, with 0 being no problem and 10 being the worst Choose an item.
2. What are your treatment goals/concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since the onset of your current symptoms have you had:**

Y/N Fever/chills

Y/N Unexplained weight change

Y/N Dizziness or fainting

Y/N Change in bowel or bladder functions

Y/N Malaise (Unexplained tiredness)

Y/N Unexplained muscle weakness

Y/N Night pain/sweats

Y/N Numbness/Tingling

Y/N Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History:**

Date of Last Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test performed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health:** Excellent Good Average Fair Poor

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On disability or leave?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Activity Restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health:** Current level of stress High Med Low

Current psych therapy? Y/N

**Activity/Exercise:**None  1-2 days/week  3-4 days/week  5+ days/week

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following conditions or diagnoses? Check all that apply/describe.**

Cancer

Heart problems

High Blood Pressure

Ankle swelling

Anemia

Low back pain

Sacroiliac/Tailbone pain

Alcoholism/Drug problem

Childhood bladder problems

Depression

Anorexia/bulimia

Smoking history

Vision/eye problems

Hearing loss/problems

Stroke

Epilepsy/seizures

Multiple sclerosis

Head Injury

Osteoporosis

Chronic Fatigue Syndrome

Fibromyalgia

Arthritic conditions

Stress fracture

Rheumatoid Arthritis

Joint Replacement

Bone Fracture

Sports Injuries

TMJ/neck pain

Emphysema/Chronic bronchitis

Asthma

Allergies-list below

Latex sensitivity

Hypothyroid

Hyperthyroid

Headaches

Diabetes

Kidney disease

Irritable Bowel Syndrome

Hepatitis HIV/AIDS

Sexually transmitted disease

Physical or Sexual abuse

Raynaud’s (cold hands and feet)

Pelvic pain

Other/Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical/Procedure History

Y/N Surgery for your back/spine

Y/N Surgery for your brain

Y/N Surgery for your female organs

Y/N Surgery for your bladder/prostate

Y/N Surgery for your bones/joints

Y/N Surgery for your abdominal organs

Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries # \_\_

Y/NEpisiotomy # \_\_\_

Y/NC-Section # \_\_\_

Y/NDifficult childbirth # \_\_\_

Y/NProlapse or organ falling out

Y/N Vaginal dryness

Y/N Painful periods

Y/N Menopause-when? \_\_\_\_\_

Y/N Painful vaginal penetration

Y/N Pelvic pain

Y/N Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Males only

Y/N Prostate disorders

Y/N Shy bladder

Y/N Pelvic pain

Y/N Erectile dysfunction

Y/N Painful ejaculation

Y/N Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications-pills, injection,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the counter- vitamins etc

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pelvic Symptom Questionnaire**

Bladder/Bowel Habits/Problems

Y/N Trouble initiating urine stream

Y/N Urinary intermittent/slow stream

Y/N Trouble emptying bladder

Y/N Difficulty stopping the urine stream

Y/N Trouble emptying bladder completely

Y/N Straining or pushing to empty bladder

Y/N Dribbling after urination

Y/N Constant urine leakage

Y/N Blood in urine

Y/N Painful urination

Y/N Trouble feeling bladder urge/fullness

Y/N Current laxative use

Y/N Trouble feeling bowel/urge/fullness

Y/N Constipation/straining

Y/N Trouble holding back gas/feces

Y/N Recurrent bladder infection

Y/N Other/describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Frequency of urination: awake hours \_\_\_\_ times per day, sleep hours \_\_\_\_ time per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
3. minutes, hours,  not at all
4. The usual amount of urine passed is:  small  medium  large.
5. Frequency of bowel movements \_\_\_\_ times per day,\_\_\_\_ times per week, or \_\_\_\_
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?  minutes,  hours,  not at all.
7. If constipation is present describe management techniques \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Average fluid intake (one glass is 8 oz or one cup) \_\_\_\_\_\_\_\_\_\_ glasses per day.
9. Rate a feeling of organ “falling out”/prolapse or pelvic heaviness/ pressure:

None present

\_\_\_\_ Times per month (specify if related to activity or your period)

With standing for \_\_\_\_ minutes or \_\_\_\_ hours.

With exertion or straining

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skip questions if no leakage/incontinence

9a. Bladder leakage- number of episodes

No leakage

\_\_\_\_ Times per day

\_\_\_\_ Times per week

\_\_\_\_ Times per month

Only with physical exertion/cough

10a. Bowel leakage- number of episodes

No leakage

\_\_\_\_ Times per day

\_\_\_\_ Times per week

\_\_\_\_ Times per month

Only with exertion/strong urge9b. On average, how much urine do you leak?

No leakage

Just a few drops

Wets underwear

Wets Outwear

Wets Floor

10b. How much stool do you lose?

No leakage

Stool staining

Small amount in underwear

Complete emptying

11. What form of protection do you wear? (Please complete only one)

None

Minimal protection (tissue paper/paper towel/pantishields)

Moderate protection (absorbent product, maxipad)

Maximum protection (specialty product/diaper)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On average, how many pad/protection changes are required in 24 hours? \_\_\_\_# of pads