Patient History

Name _____ Age _____ Date _____

OB/GYN Doctor: _____

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 Please Describe and specify date: _____
   _____
4. Since that time is it: staying the ___ same ____getting worse _____ getting better? Why or How?
   _____
5. If pain is present rate on a 0-10 scale, 10 being the worst. _____ Describe the nature of the pain (i.e. constant burning, intermittent ache) _____
   _____
6. Describe previous treatment/exercises _____
   _____
7. Activities/events that cause or aggravate your symptoms. Check/circle 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 life/jump)
   ___ Sexual activity
   ___ With cough/sneeze/straining
   ___ With laughing/yelling
   ___ With lifting/bending
   ___ With cold weather
   ___ With triggers –running water
   ___ With nervousness/anxiety
   ___ No activity affects the problem
   ___ Other, Please list _____
8. What relievers your symptoms? _____
   _____
9. 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 _____
10. Rate the severity of this problem from 0- 10 with 0 being no problem and 10 being the worst: _____
11. What are you treatment goals/concerns? _____
    _____

Pg 2 History **Name: _____**

Since the onset of your symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness/ Tingling
Y/N	Other/describe: _____		

Heath 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? circle all that apply /describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe: _____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #__	Y/N	Vaginal dryness
Y/N	Episiotomy #__	Y/N	Painful periods
Y/N	C-Section #__	Y/N	Menopause - when? __
Y/N	Difficult childbirth #__	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe_____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe_____		

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 Other/describe _____

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 infections

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night

2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ____minutes, __hours, ____not at all

3. The usual amount of urine passed is: ___small ___ medium___ large.

4. Frequency of bowel movements __times per day, ____times per week, or ____.

5. 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.

6. If constipation is present describe management techniques _____

7. Average fluid intake (one glass is 8 oz or one cup) ____glasses per day.
Of this total how many glasses are caffeinated?_____glasses per day.

8. 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

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying
__ Wets the floor

Page 4 Symptoms **Name**_____

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 _____

12. On average, how many pad/protection changes are required in 24 hours? __# of pads

Medications - pills, injection, patch	Start date	Reason for taking

Over the Counter- vitamins, etc.	Start date	Reason for taking

Other Information: