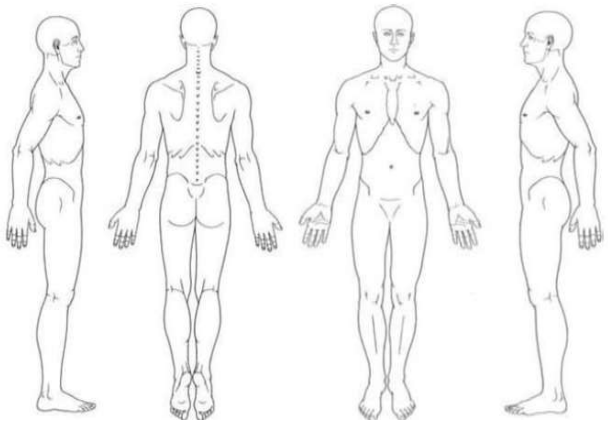
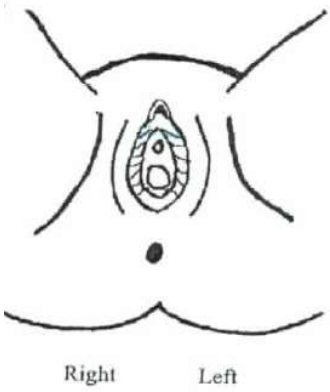
Women's Health Questionnaire

Date: _____

Answering the following questionnaire will help us to manage your health better. Please complete all pages.		
Patient Name:		Date of Birth:
Occupation:	Are you still working? YES NO	
Has your physician placed you on any work restrictions? YES NO		
If yes, please explain:		

Current symptoms: Please mark the diagram in the areas affected using: X = Pain ~ = Tingling/Numbness





Pain (circle all that apply):

Constant	Intermittent	Burning	Sharp	Dull	Radiation
Location:					

Rate your pain by marking an "X" on this scale:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Pelvic Health			
Last doctors visit:	Last Pelvic Exam:	Last Urinalysis:	
Previous test for the condition for which you are coming to physical therapy:			
If you have or have had a history of any of the following, if yes, please explain in the space provided below:			
(Please check all that apply)			
	Bladder Infections		Gastrointestinal Problems
	Yeast Infections		Pain with Climbing Stairs
	Pelvic Pain		Thyroid Disorder
	Sciatica		Constipation
	Childhood Bladder Problems		Abdominal Pain
	Sexual Abuse		Blood in Stool
	Sexually Transmitted Diseases		Painful Bowel Movements

	Trouble Achieving Orgasm		Irritable Bowel Syndrom (IBS)
	Trouble Initiating Urine		Inflammatory Bowel Disease
	Trouble Emptying Bladder		Trouble Feeling Bowel Urge/Fullness
	Dribbling of Urine		Trouble Emptying Bowel
	Slow Urine Stream		Trouble Holding Back Gas
	Trouble Feeling Bladder Urge/Fullness		Fecal Incontinence
	Painful Urination		Endometriosis
	Painful Penetration/Intercourse		Vaginal Dryness
	Painful Menstrual Cycles		Irregular Menstrual Cycles
	Menopause - Date of Last Period:		Difficult Childbirth
	Felvic Infections/Inflammatory Disease		Fibroids/Cysts
Explanation:			

Pregnancy History							
Number of pregnancies:			Are you pregnant or trying to get pregnant?				
Delivery Dates	Birth Weights	Full Term - 9 months	Premature Delivery	Miscarriage or Abortion	C-Section	Episiotomy Tear or Forceps	Living Children
Explaination of Above Responses:							

Bladder Questionnaire			
Describe the reason for the appointment:			
When did the problem begin?			
Does the problem cause you to change your schedule or lifestyle? YES NO If yes, explain:			
List the problems that you are unable to do because of this problem:			
Please check the appropriate responses:			
Bladder leakage frequency - Number of Episodes			
	Never	Number of leaks you have per month? _____ Number of leaks you have per week? _____ Number of leaks you have per day?	
	Only with exertion		
	Only Premenstrual		
	Constant Leakage		
Severity of Leakage			
	No leak		Wets underwear
	Few drops		Wets outerwear
Protection Worn			
	None		Tissue paper/Paper Towels
	Pantiliner		Minipad
	Maxipad		Special product - brief name:
Are they... Damp - Wet - Saturated (circle applicable) How many per day?			
Leakage caused by or increased by: (check all that apply)			
	Vigorous activity or exercise		Sleeping
	Light activity (walking, light housework)		Nervousness/Anxiety
	Changing postions (sit to stand)		Laughing
	Walking to toilet		Coughing/Laughing

	Strong urge to go		No activity - constant leakage despite activity
	Intercourse or sexual activity		Other:

Position or Activity with Leakage

	Lying down
	Sitting
	Standing

How long can you delay the need to urinate?

	Not at all		11-30 minutes
	1-2 minutes		31-60 minutes
	3-10 minutes		_____ Hours (add the number)

Rate a feeling of "falling out" or pelvic heaviness/pressure

	None present		With excertion or strain
	_____ Times per month (indicate the number)		At the end of each day
	Only with menstruation		Present all day
	With standing		

Please list your fluid intake (one glass is 8 ounces or 1 cup)

Glasses per day _____

Caffinated glasses per day _____

Alchoholic beverages per day _____

Bladder habits:

How often do you urinate during the day?_____

How often do you urinate after going to bed?

_____

Do you take your time to go to the toilet and empty your bladder? YES NO

How many bladder infections did you have last year?

_____

Can you stop the flow of urine when on the toilet? YES NO

Is the volume of urine passed usually:

_____ Large

_____ Average

_____ Small

_____ Very small

Do you always have the sensation that you need to go to the toilet? YES NO

Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc.) YES NO If yes, please list:_____

_____

Do you change your daily schedule to accommodate your bladder habits? YES NO

Bowel habits:

Frequency of bowel movements:

_____ Per day _____ Per Week

Consistency of stool:

Loose_____ Normal _____ Hard _____

Do you strain to go? YES NO

Do you ignore the urge to defecate? YES NO

Do you have trouble making it to the toilet when you have the urge to go? YES NO

Other:

Are you sexually active? YES NO

Have you ever been taught how to do Kegal exercies? YES NO

If yes, how often do you do them?

_____

Any comments/concerns not addressed?

_____

_____

_____

_____

Are you taking any medications? YES NO

If yes, please list: _____

_____

Rate your feeling to the severity of this problem from 1-10:

1	2	3	4	5	6	7	8	9	10
No Problem									Major Problem

Rate the following statement as it applies to you today: "My bladder is controlling my life."

1	2	3	4	5	6	7	8	9	10
Not true									Completely true

Medical History – Check any applicable conditions					
	Alcoholism/Drug Use		Falling inside/outside home		Parkinsons
	Anemia		Fibromyalgia		Peripheral Vascular Disease
	Ankle Swelling		Head Injury		Polio
	Arthritis/Gout/Joint Pain		Headaches		Shortness of Breath
	Asthma/Allergies		Hepatitis		Skin Problems
	Broken Bones		High/Low Blood Pressure		Smoking
	Bowel/Bladder Problems		Kidney Disease		Stroke/CVA
	Cancer – Location:		Loss of Sensation/Function		Thyroid
	Caridac Condition		Metal Implants		Tumors – Location:
	COPD/Emphysema		Multiple Sclerosis/Neurologic Problems		Ulcers/Stomach Problems
	Depression		Muscular Pystrophy		Unexplained Weight Loss
	Diabetes		Osteoporosis		Vision/Hearing Problems
	Epilepsy/Seizures		Pacemaker		Other:

Briefly describle how and when your symptoms began:
_____
_____

Who have you seen for your symptoms (circle all that apply):

Medical Doctor	Chiropractor
Physical Therapist	Other

Diagnostic Testing (circle all that apply):

X-Ray	MRI	CT

Findings: _____
_____

Have you had a previous injury to this or related region? YES NO
If yes, please explain and provide the dates of injury:
_____
_____

Do you have increased pain at night?
YES NO
Pain with coughing/sneezing?
YES NO
Dizziness/Nausea?
YES NO
Have you had any episodes of losing control of your bowel or baldder function since injury?
YES NO
Have you had any surgeries?
YES NO
If yes, please explain and provide the dates:
_____
_____

Pain (circle all that apply):

Constant	Intermittent	Burning
Sharp	Dull	Radiation
Location:		

Symptoms that are aggravated by (circle all that apply):
Sitting longer than _____ minutes.
Walking longer than _____ minutes.
Lifting _____ pounds.
Turning head while driving.
Compter work
Reaching overhead
Yardwork

House work - specify activities:
_____
Hobbies/Sports - Specify activities:
_____
Other:
_____
Do you have any allergies? YES NO
If yes, please list:
_____
_____

Questionnaire review with patient?

Therapist signature: _____

Patient Signature: _____ Date: _____