



## Patient History- Womens Health

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  
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 pain 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

<input type="checkbox"/> Sitting greater than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking greater than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing greater than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (ie. - sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers -running water/key in door
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	

8. What relieves 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 your treatment goals/concerns? \_\_\_\_\_  
\_\_\_\_\_

### Since the onset of your current 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 _____		

\_\_\_\_\_

**Health History:** Date of Last Physical Exam \_\_\_\_\_ Tests 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 _____ |                    |     |                      |

<u>Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Pelvic Symptom Questionnaire**Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Other/describe _____		

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  
 Wets the 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