Name:

DOB:

Today's Date:

Patient History

1. Describe the current problem that brought you here:

   _____

2. When did your problem first begin? (months, years):

   _____

3. Was your episode of the problem related to a specific incident?: YES/ NO

   Please describe and specify date:

   _____

4. Since that time is your condition:
   a. Staying the same
   b. Getting Worse
   c. Getting better
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 treatments/exercises

   _____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply.
   a. Sitting greater than _____ min
   b. Walking greater than _____ min
   c. Standing greater than _____ min
   d. Changing positions (sit to stand, laying down to sitting up)
   e. Light activity
   f. Vigorous activity/exercise (run,weight lift, jumping)
   g. Sexual Activity
   h. With cough/sneeze/straining
   i. With laughing/yelling
   j. With lifting/bending
   k. With cold weather
   l. With triggers -running water/ key in the door
   m. With nervousness/anxiety
   n. Other, please list
      _____
   o. No activity affects the problem

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8. What relieves your symptoms?

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9. How has your lifestyle/quality of life been altered/changed because of this problem?
    a. Social activity (excluding physical activities):
    b. Diet/Fluid intake:
    c. Physical Activity:
    d. Work (specify):
10. What are your treatment goals/concerns?

Since the onset of your current symptoms have you had:

Yes/No Fever/Chills	Yes/No Malaise (unexplained tiredness)
Yes/No Unexplained weight changes	Yes/No Unexplained muscle weakness
Yes/No Dizziness or fainting	Yes/No Night pain/sweats
Yes/No Change in bowel or bladder functions	Yes/No Numbness/ Tingling
Other (please describe):	

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Health History

Date of last physical exam: _____

Tests performed: _____

General Health: Excellent Good Average Fair Poor

Occupation: Hours per week:

Mental Health: Current level of stress: High Med Low Current psych therapy? Yes/No

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

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies
Ankle Swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug use	Arthritic Conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid arthritis	Hepatitis
Anorexia/bulimia	Joint Replacement	HIV/AIDS
Smoking history	Bone Fracture	Sexually transmitted disease
Vision/eye problems	Sports Injuries	Physical or sexual abuse
Hearing loss/problems	TMJ/ neck pain	Raynauds (cold hands/feet)
		Pelvic Pain

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Surgical Procedure History

Surgical history (Body part and year):

_____

_____

OBGYN History (Circle and explain) :

Childbirth vaginal deliveries #_____
Episiotomy # _____
C-Section # _____
Prolapse or organ falling out
Vaginal dryness
Painful periods
Menopause- When? _____
Painful vaginal penetration
Pelvic Pain

Medications (Prescribed, Vitamins, Supplements, Pills, Injections, and Patches):

_____

_____

_____

_____

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Pelvic Symptom Questionnaire

Bladder/Bowel Habits/Problems (Circle all that apply)

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

1. Frequency of urination:
    a. Awake hours _____/per day
    b. Sleep hours _____/ per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
    a. _____ minutes
    b. _____ hours
    c. _____ not at all
3. The usual amount of urine passed is:
    a. Small
    b. Medium
    c. Large
4. Frequency of bowel movements:
    a. _____ times per day
    b. _____ times per week
5. If constipation is present describe management techniques:

_____

_____

6. Average fluid intake (1 cup is 8 oz) _____ per day
7. Of this total, how many of the beverages are caffeinated? _____

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8. Rate a feeling of organ "falling out" /prolapse or pelvic heaviness
    a. None present
    b. _____ Times per month
    c. With standing for _____ minutes or _____ hours
    d. With exertion or straining
    e. Other:

Skip questions if no leakage/incontinence

9. Bladder leakage - number of episodes
    a. No leakage
    b. ____ times per day
    c. ____ times per week
    d. ____ times per month
    e. Only with physical exertion/cough
10. Bowel leakage- number of episodes
    a. No leakage
    b. ____ times per day
    c. ____ times per week
    d. ____ times per month
    e. Only with exertion/ strong urge
11. On average, how much urine do you leak?
    a. No leakage
    b. Just a few drops
    c. Wets underwear
    d. Wets outerwear
    e. Wets the floor
12. How much stool do you lose?
    a. No leakage
    b. Stool staining
    c. Small amount in underwear
    d. Complete emptying
13. What form of protection do you wear (Please complete only one)
    a. None
    b. Minimal protection (Tissue paper/paper towel/ pantliner)
    c. Moderate protection (Absorbent pad, maxipad)
    d. Maximum protection (specialty product/ diaper)

On average, how many pad/protection changes are required within 24 hours? _____