Patient History

Name _____ Age _____ Date _____

1. **Describe the problem that brought you here?**
   _____
   _____

2. **When did your problem first begin? _____**

3. **Was your first episode of the problem related to a specific incident/injury? Yes/No**

   Please describe and specify date:
   _____
   _____

4. **Since that time/injury is it: _____ same _____ getting worse _____getting better**
5. **If pain is present, describe pain (ie. constant, burning, intermittent ache): _____**
6. **Describe any previous treatments/exercises:**

   _____

   _____

7. **Check activities that may aggravate your symptoms (any/all that apply)**

_____ Sitting greater than ___ minutes

_____ Walking greater than ___ minutes

_____ Standing greater than ___ minutes

_____ Changing positions (ie. sit to stand)

_____ Light activity (ie. housework)

_____ Vigorous activity (ie. running, jumping, weightlifting)

_____ with sexual activity

_____ with cough/sneeze

_____ with laughing/yelling

_____ with lifting/bending

_____ with cold weather

___ with triggers (ie. running water or key in door)

___ with nervousness/anxiety

___ No activity affects this problem

_____ Other: _____

8. **What relieves your symptoms?**

_____

9. **What are your treatment goals/concerns?**

_____

Health History:

Date of last gynecology exam: _____ Tests performed: _____

_____

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

Have you ever had or experienced any of the following? (circle all that apply)

Cancer
Heart Problems
High Blood Pressure
Ankle Swelling
Anemia
Low Back Pain
SI joint/Tailbone pain
Childhood Bladder Problems
Depression
Anorexia/Bulimia
Smoking History
Stroke
Multiple Sclerosis
Osteoporosis
Fibromyalgia
Rheumatoid Arthritis
Allergies (list below)
Hypothyroidism/Hyperthyroidism
Headaches
Irritable Bowel Syndrome
Sexually Transmitted Disease
Physical or Sexual Abuse
Pelvic Pain
Other/Describe: _____

Surgical/Procedure History: Please list and describe procedures to the back/spine, brain, female organs, bladder/prostate, bones/joints, and/or abdominal organs:

_____
_____

OB/GYN History:

Y/N Childbirth vaginal deliveries #_____

Y/N Episiotomy # _____

Y/N C-Section # _____

Y/N Difficult Childbirth # _____

Y/N Prolapse 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

Medications:

_____

_____

Bowel/Bladder Habits:

Y/N Trouble initiating stream

Y/N Urinary intermittent/slow stream

Y/N Trouble emptying bladder completely

Y/N Difficulty stopping the urine stream

Y/N Dribbling after urination

Y/N Constant urine leakage

Y/N Blood in the 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

1. **Frequency of urination: awake hours = _____ times per day, sleep hours = _____ times per night**
2. **The usual amount of urine passed is: _____ small _____ medium _____ large**
3. **Frequency of bowel movements _____ times per day, _____ times per week, or describe _____**
4. **Average fluid intake for the day? (include water and other drinks)**
   _____
5. **Describe the feeling if you have "falling out" feeling of your organs/prolapse/or pelvic heaviness. Specify whether it is occasionally, with prolonged standing, activity, etc.)**
   _____
   _____

6. **If you are having incontinence/leakage, how many times a day or week do you leak, or is it only with physical exertion/cough?**

   _____

   _____

7. **If you have leakage, how much do you leak on average? (ie. a few drops, wets underwear, wets outerwear, etc.)**

   _____

   _____