PHYSICAL THERAPY CARE & AQUATIC REHAB OF FORT BEND
professional care with a personal touch

Women's Health History

Name_____Age_____Date_____

1. What are your current symptoms? _____
   _____
2. Onset of problems? _____ 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. If pain is present, rate pain on a 0-10 scale. 10 being the worst. _____ Describe the pain (i.e. constant burning, intermittent ache) _____
   _____
5. Describe previous treatment/exercises _____
   _____
6. Activities/ events that cause or aggravate your symptoms. Check all that apply.

___Sitting greater than ____ minutes	___With cough/sneeze/straining
___Walking greater than ____ minutes	___With laughing/yelling
___Standing greater than ____ minutes	___With lifting/bending
___Changing positions (i.e. – sit to stand)	___With cold weather
___Light activity (light housework)	___With triggers –running water/key in door
___Vigorous activity/exercise (run/weight lift/jump)	___With nervousness/anxiety
___Sexual Activity	___No activity affects the problem

   ___Other, please list _____
7. What relieves your symptoms? _____
   _____
8. 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 _____

9. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst _____
10. Occupation_____ Hours/week _____On disability or leave? _____ Activity restrictions? _____
11. Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N
12. Activity/Exercise: None____ 1-2 days/week____ 3-4 days/week____ 5+ days/week____ Describe_____
13. Do you have a history of sexual abuse or trauma? Y / N

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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	Sport Injuries	Raynaud's (cold hands and feet)
Hearing loss/ problems	TMJ/ neck pain	Pelvic Pain

Other/Describe_____

Surgical/ Procedure History

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 of organ falling out	Y/N	Pelvic pain
Y/N	Pain with pelvic exam	Y/N	Pain with Tampon use
Y/N	Other/Describe_____		

Medications/Over the Counter/Vitamins Start date

_____

_____

_____

_____

_____

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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

9. 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

10. 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

_____
Signature **Date**