MEDICAL HISTORY QUESTIONNAIRE
PFT

Name: ____ Date of Birth: ______________

Height: _____________ Weight: ___________

Describe the current problem: ____

____

When did the problem begin? ____

Has the problem stayed - The Same | Better | Worse

Do you have pain? Y / N

Please rate the pain 0 - 10 ______ (0 is no pain, 10 is horrible pain)

Please describe the type of pain: ____

Have you had previous treatments? ____

Have you fallen in the past year? _________ How many times? _________

Pain

Y / N Pain wearing tight clothing?
Y / N Pain with sitting?
Y / N Pain with bowel movement?
Y / N Pain with speculum exams?
Y / N Pain with sexual intercourse?
Y / N Pain worsens with walking?
Y / N Require pain medication?
Y / N Limited social outings due to pain?
Y / N Pain inserting tampon?

Activities/events that cause or aggravate your symptoms. Check/circle all that apply.

__ Sitting greater than _____ minutes
__ Walking greater than _____ minutes
__ Standing greater than _____ minutes
__ Changing positions (i.e - sit to stand)
__ Light activity (light housework)
__ Vigorous activity/exercise (run/weight lift/jump)
__ Sexual activity
__ With cough/sneeze/straining
__ With laughing/yelling
__ With lifting/bending
__ With cold weather
__ With triggers - running water/key in door
__ With nervousness/anxiety
__ No activity affects the problem

How has your lifestyle/quality of life been altered/changed because of this problem?

___

Have social activities been affected? Y / N Specify (exclude physical activities)

___

Has diet/fluid intake been affected? Y / N Specify ___

Has physical activity been affected? Y / N Specify ___

Has work been affected? Y / N Specify ___

Other ___

Rate the severity of this problem from 0-10 (0 being no problem and 10 being the worst) ___

What relieves your symptoms? ___

What are your treatment goals/concerns? ___

Since the onset of your current symptoms have you had:

Y / N Fever/Chills

Y / N Unexplained weight change

Y / N Dizziness or fainting

Y / N Change in bowel or bladder functions

Y / N Malaise (Unexplained tiredness)

Y / N Unexplained muscle weakness

Y / N Night pain/sweats

Y / N Numbness/Tingling

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 ___ Medium ___ Low ___

Current psychological 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 & 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 brain
Y / N Surgery for your female organs
Y / N Surgery for your bladder/prostate
Y / N Surgery for your bones/joints
Y / N Surgery for your abdominal organs

Other/Describe: ____

Ob/Gyn History (females only)

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

Other/Describe: ____

Males Only

Y / N Prostate disorders
Y / N Shy bladder
Y / N Pelvic Pain
Y / N Erectile dysfunction
Y / N Painful ejaculation

Other/Describe: ______________________________

Medications - pills, injection, patch	Start date/dosage	Reason for taking

Over the counter vitamins, etc.	Start date/dosage	Reason for taking

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 Pain with bowel movement
Y / N Trouble emptying with bowel movement
Y / N Leaking of feces
Y / N Abdominal pain
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
Y / N Recurrent bladder infections
Y / N Pain with sexual intercourse
Y / N Smearing of feces in underwear
Y / N Feelings of bloating or gassiness

Frequency of urination: Times per day ______
Times per night (during bedtime) ______

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ________________________________

The usual amount of urine passed is: ____ Small ____ Medium ____ Large

Frequency of bowel movement: __________________________

Do you have a regular bowel schedule? Y / N

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____________________

If constipation is present, please describe management techniques:

____

What is the consistency of bowel movements: Hard | Soft Solid | Soft not solid

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.

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 this page if you don't experience leakage/incontinence

Bladder leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

On average, how much urine do you leak?

___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

How much stool do you lose?

___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Is the stool formed or loose?

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

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