PELVIC FLOOR MEDICAL HISTORY

Name:________________________________Date of birth:________________

Diagnosis:____

Referring Physician:____

Overview of when your symptoms started:________________________________

____

How do your symptoms limit your function?_____________________________

____

Have you had tests or intervention for your diagnosis?______________________

____

Gynecologic History:

Pre-menopause:_______Peri-menopause:________Post-menopause:________

Pelvic pain: Y / N ____

Pain scale: 0-10, 10=worst and with what activity:

present_____________________________average_________________________

best_________________________________ worst___________________________

Quality: burning / dull / throbbing / itching / raw / shooting / other_____________

____

Endometriosis: Y / N ____

Painful periods: Y / N ____

Painful intercourse: Y / N ____

Fibroids or cysts: Y / N ____

PID or STD: Y / N ____

Yeast infections: Y / N ____

Prolapse: (pressure or falling out feeling): Y / N ___________________________

____

Sexual abuse: Y / N ____

PLATINUM
PHYSICAL THERAPY

Obstetric History:

# of vaginal births & dates:_______________________________________

Episiotomies____

# of cesarean births & dates:_____________________________________

Pregnancies:____

Bladder History:

Urine loss? Yes / No, describe____________________________________

____

Urinary Symptoms (Key: 0=none, 1=mild, 2=moderate, 3=severe)

1. Urgency:____
2. Urine loss with urge:______________________________________
3. Urine loss with sneeze/cough/laugh:_________________________
4. Urine loss with exercise/lifting:____________________________
5. Slow / weak / interrupted stream:___________________________
6. Difficulty initiating stream:_________________________________
7. Post-void dribble:____
8. Incomplete emptying:______________________________________
9. Pain / burning with void:___________________________________

Do you get up at night to void: Y / N How often?________________________

How often do you void during the day:___________________________

Fluid intake/day, please describe type of beverage and quantity:____________

____

Do you use pads? Y / N Does this irritate your skin?____________________

Quantity per day:___ Type of pad: thin liners / medium / thick

After starting urination, can you stop / slow the stream of urine?____________

Can you delay the need to urinate: No / 1-2 minutes / 10-15 minutes / ½ hr

Urinary tract infections:____

Did you have urinary issues as a child?_____________________________

Bowel History:

Consistency: Normal:_____ Loose:_____ Hard:____

Frequency that you move your bowels:______/day or_______/week

Constipation: Yes / No / Occasional Hemorrhoid: Y / N

Fecal Incontinence: Y / N ____

Do you feel the urge to go: Y / N ______________________________________

General Medical History:

List any medical issues that you have:_________________________________
____
____
____

List over the counter and prescription medications:
____
____
____
____
____
____

Past Hospitalizations / Surgeries, include dates:__________________________
____
____
____

Do you have any neurological issues? Y / N ____________________________
Allergies: Latex: Y / N Lubricant: Y / N Other:_________________________
Chronic cough:____
Smoker: Y / N if yes, amount:_______________________________________

Patient Signature:______________________________Date:_________________