

Pelvic Health Patient History

Patient Name: _____ Date of Birth: _____ Date: _____

Current Symptom:

What is the current problem that brought you here?

When/How did this start?

What makes your symptoms better?

What make your symptoms worse?

What activities do you feel limited in because of your symptoms?

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

How much and what type of exercise do you regularly do?

How much water do you drink daily?

How much caffeine do you drink daily?

How do you achieve stress reduction?

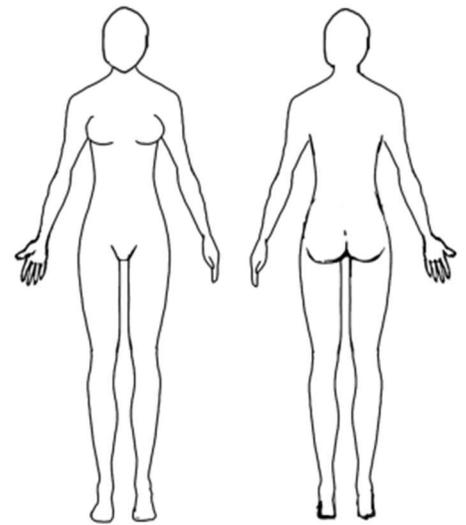
How much sleep to you get on average?

How would you describe your quality of sleep?

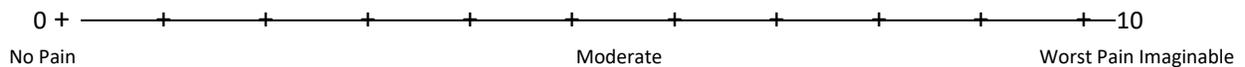
Activities/events that cause or aggravate your symptoms: (check/circle all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Sitting greater than ____ minutes | <input type="checkbox"/> Cough/Sneeze/Strain | <input type="checkbox"/> Light activity/Housework |
| <input type="checkbox"/> Walking greater than ____ minutes | <input type="checkbox"/> Laughing/Yelling | <input type="checkbox"/> Triggers (running water/key in door) |
| <input type="checkbox"/> Standing greater than ____ minutes | <input type="checkbox"/> Lifting/Bending/Reaching | <input type="checkbox"/> Nervousness/Anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Cold weather | <input type="checkbox"/> Changing positions (i.e. sit to stand) |
| <input type="checkbox"/> Vigorous activity/Exercise (run/lift weights/jump/ride a bike) | | <input type="checkbox"/> Other, please explain: |

Please indicate on body chart below the location of pain or discomfort.



Pain Intensity: Rate your pain by marking an 'X' on the following scales:



Pelvic Health History:

Approximate date of last gynecological exam:

Known findings from any tests/exams performed:

Approximate date of last menstruation:

Frequency of menstruation:

Are you in perimenopause? Yes No Are you in menopause? Yes No

When did it start?

Patient Name: _____

OB/GYN History: (check & describe all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Births: vaginal #: | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Prolapse |
| c-section #: | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Difficult labor/childbirth | <input type="checkbox"/> Pelvic/genital pain | <input type="checkbox"/> Digestive issues with your cycle |
| <input type="checkbox"/> Episiotomy/tear | <input type="checkbox"/> Pain with sexual intimacy | <input type="checkbox"/> Hormone therapy |
| <input type="checkbox"/> Pain with tampon use | <input type="checkbox"/> PCOS | <input type="checkbox"/> Other, explain: |

Please list current medications/supplements and doses including the reason you are taking each medication:

Medical History: Please check if you have ever had: (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Malaise (unexplained tiredness) | <input type="checkbox"/> Hypermobility |
| <input type="checkbox"/> Bladder changes | <input type="checkbox"/> Unexplained weight change | <input type="checkbox"/> Unexplained muscle weakness | <input type="checkbox"/> GERD/Reflux |
| <input type="checkbox"/> Bowel changes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiac/heart condition | <input type="checkbox"/> Lung problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Spinal cord injury | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Smoking history/currently | <input type="checkbox"/> Hyper or hypo thyroid | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> TMJ/jaw pain | <input type="checkbox"/> Sacroiliac/tailbone pain | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Physical or sexual abuse | <input type="checkbox"/> Brain/head injury |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blood clot | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Childhood bladder problems | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Drug/alcohol addiction | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Autoimmune problems | <input type="checkbox"/> Frequent falls, trips, slips | <input type="checkbox"/> Other, please explain: |

Surgeries: Please check if you have ever had surgery related to the following: (please include year)

- | | | | |
|---|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Neck/spine | <input type="checkbox"/> Joints/bones | <input type="checkbox"/> Female organs | <input type="checkbox"/> Abdominal |
| <input type="checkbox"/> Bladder/bowel | <input type="checkbox"/> Brain | <input type="checkbox"/> Heart | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other, please explain: | | | |

Allergies: Allergies or sensitivity to latex: Yes No Other Allergies: Yes No please explain:

Sensory: Are you sensitive to any of the following? (check all that apply and briefly explain what you experience in those situations):

- | | | |
|--|---|---|
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Walking through the detergent section at a store | <input type="checkbox"/> Bright lights |
| <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Clothing with tags or scratchy material | <input type="checkbox"/> Perfumes |
| <input type="checkbox"/> Household background noise (for example fans, appliances running) | | <input type="checkbox"/> Walking barefoot |

How would you describe you overall general health?

What have you done to manage your current condition: Treatments, Specialists, Medications, Home Programs?

What level of change are you willing to make in daily life to improve your health? (check one)

- Whatever it takes Significant change Some change No change

Is there anything else you would like us to know?

Goals: What are your goals and expected outcomes for pelvic floor therapy?

Patient Signature

Date

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