# Women’s Health Patient History

**Name Age Date**

1. Describe the current problem that brought you here?

2. When did your problem first begin? 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. Since that time is it: staying the same getting worse getting better

Why or how?

5. If pain is present rate pain on a 0-10 scale 10 being the worst. Describe the nature of
 the pain (i.e. constant burning, intermittent ache)

6. Describe previous treatment/exercises

7. Activities/events that cause or aggravate your symptoms. Check/circle 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 (ie. - 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

8. What relieves your symptoms?

9. 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

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst \_\_

11. What are your treatment goals/concerns?

**Since the onset of your current symptoms have you had:**

Y/N Fever/Chills Y/N Malaise (Unexplained tiredness)

Y/N Unexplained weight change Y/N Unexplained muscle weakness

Y/N Dizziness or fainting Y/N Night pain/sweats

Y/N Change in bowel or bladder functions Y/N Numbness / Tingling

Y/N Other /describe

**Pg 2 History Name**

**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 Med Low Current psych 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 and 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 bladder

Y/N Surgery for your brain Y/N Surgery for your bones/joints

Y/N Surgery for your female organs Y/N Surgery for your abdominal organs

Other/describe

**Ob/Gyn History**

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 or organ falling out Y/N Pelvic pain

Y/N Other /describe

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

Over the counter -vitamins etc Start date Reason for taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pelvic Symptom Questionnaire

### Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream Y/N Blood in urine

Y/N Urinary intermittent /slow stream Y/N Painful urination

Y/N Trouble emptying bladder Y/N Trouble feeling bladder urge/fullness

Y/N Difficulty stopping the urine stream Y/N Current laxative use

Y/N Trouble emptying bladder completely Y/N Trouble feeling bowel/urge/fullness

Y/N Straining or pushing to empty bladder Y/N Constipation/straining

Y/N Recurrent bladder infections Y/N Trouble holding back gas/feces

Y/N Constant urine leakage

Y/N Other/describe

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

9a. Bladder leakage - number of episodes 9b. Bowel leakage - number of episodes

\_\_\_ No leakage \_\_\_ No leakage

\_\_\_ Times per day \_\_\_ Times per day

\_\_\_ Times per week \_\_\_ Times per week

\_\_\_ Times per month \_\_\_ Times per month

\_\_\_ Only with physical exertion/cough \_\_\_ Only with exertion/strong urge

10a. On average, how much urine do you leak? 10b. How much stool do you lose?

\_\_ No leakage \_\_ No leakage

\_\_ Just a few drops \_\_ Stool staining

\_\_ Wets underwear \_\_ Small amount in underwear

\_\_ Wets outerwear \_\_ Complete emptying

\_\_ Wets the floor

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

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