Pregnancy/Postpartum History and Screening Questionnaire

Patient Name: ____ **Date:** __________

General Health History

Please **CHECK** any of the following health conditions that you have now, or have had in the past:

☐ Anemia	☐ Hepatitis	☐ Migraines	☐ Seizures
☐ Anxiety	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Stroke
☐ Blood in Urine	☐ History of Fractures	☐ Osteoarthritis	☐ Thyroid Disease
☐ Cancer	☐ Kidney Disease/Infection	☐ Osteoporosis/Osteopenia	☐ Tuberculosis
☐ Depression	☐ Latex Sensitivity/Allergy	☐ Overweight	☐ Unexplained Weight Loss
☐ Diabetes	☐ Low Back Pain	☐ Pelvic Pain	☐ UTIs/ Bladder Infection
☐ Emphysema	☐ Mental Health Condition	☐ Rheumatoid Arthritis	☐ NONE
☐ Heart Problems/Conditions	☐ History of Sexual Abuse/Trauma	☐ Internal Foreign Objects (IUD, pacemaker, lap band, staples, etc.)	

☐ Other (please briefly describe): ____

Please list any surgeries you have had (with concurrent dates). Please write <u>none</u> if you have not had any surgeries.

____

____

____

Please list any medications and/or supplements you are taking (over-the-counter and prescriptions) along with the dosage. (Please be specific.)

Medication	**Dosage**

Other Health History

If you have any other important information regarding your health, that you would like to share with your physical therapist, please briefly describe that information: ______________________________

____

____

Patient History and Symptoms

Please fill in the following questionnaire to the best of your ability.

What is the primary reason you are seeking care? ______________________________

____

When did your symptoms begin? (Approximate date if known) ____________________

Flip Over

Pain Levels, Signs, and Symptoms

Please **CHECK** if you are experiencing any of the following signs or symptoms:

☐ Abdominal Pain ☐ Groin Pain ☐ Hip Pain ☐ Low Back Pain
☐ Pelvic Pain ☐ Pubic Pain ☐ SI Joint Pain ☐ **NONE**

☐ Other (please briefly describe): ______________________________

Please **CHECK** how you would describe your symptoms:

☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Numb
☐ Sharp ☐ Shooting ☐ Sore ☐ Throbbing ☐ Tight

☐ Other (please briefly describe): ______________________________

Please briefly describe, if any, specific activities/instances that make your symptoms **WORSEN**: ______________
____

Please briefly describe, if any, specific interventions that will make your symptoms **BETTER**: ______________
____

Please rate your symptoms on a scale of 0-10 (10 being the worst) by **CIRCLING** the number that best resembles your pain level:

0	1	2	3	4	5	6	7	8	9	10
No Hurt		Hurts Little Bit		Hurts Little More		Hurts Even More		Hurts Whole Lot		Hurts Worst

Obstetrics Health History

Number of Weeks Pregnant/Postpartum:	Number of Pregnancies:
Number of Vaginal Deliveries:	Number of Cesarean Deliveries:
Number of Episiotomies:	Birth Weight of Largest Baby: ______lbs. ________oz.

Have you had any trouble healing after delivery? ☐ No ☐ Yes (please describe):______________________________

Are you having regular periods/menstrual cycles? ☐ No ☐ Yes (please describe): ______________________________

Have you struggled with fertility? ☐ No ☐ Yes (currently or past, please describe): ______________________________
____

If you are currently breastfeeding/pumping please answer the following questions; if not, skip this section:

Are you currently breastfeeding, breast pumping, or supplementing (i.e., formula, solid food)? ______________________
____

Have you or are you currently experiencing mastitis, clogged ducts, or neck/shoulder/back pain related to feeding/pumping? If yes, please explain. ______________________________
____

How many times are you breastfeeding per day/night? _____Times per day _____Times per night

Are you using one or both breasts? One Both

How many times are you breast pumping per day/night? _____Times per day _____Times per night

Are you using one or both breasts? One Both

Are you pumping before, after, between feeds, or exclusively? Before After Between Exclusively

What is the approximate volume (in ounces) per pumping session? ________ounces

Please **CHECK** all the locations that you are experiencing pain (if any) during or after breastfeeding/pumping:

☐ Back ☐ Breast ☐ Neck ☐ Nipple/Areola ☐ Shoulder

☐ Other (please briefly describe): ______________________________

Please **CHECK** all the symptoms that you are experiencing pain (if any) during or after breastfeeding/pumping:

☐ Breast Pain ☐ Cracked Nipples ☐ Dry Skin ☐ Nipple Pain ☐ Nipple Dryness
☐ Over Supply ☐ Redness ☐ Swelling ☐ Under Supply ☐ NONE

Other (please briefly describe): ______________________________

Does your baby have any difficulty with latching during feeds ☐ Yes ☐ No

Bladder Health History

How many times do you urinate during the day? ______ times per day

And at night after going to bed? ______ times per night

After emptying your bladder, do you feel like you're not finished? ☐ Yes ☐ No

Do you have any pain, burning, or stinging when emptying your bladder? ☐ Yes ☐ No

Do you have a slow, stop/start, or hesitant urine stream? ☐ Yes ☐ No

After you urinate, do you experience any dribbling of urine? ☐ Yes ☐ No

Do you get strong urges to urinate? ☐ Yes ☐ No

If yes how often? ________________

If you are experiencing urinary leakage, please answer the following questions; if not, please skip this section:

Do you experience any leakage of urine? ☐ Yes ☐ No

Do you have sensation/awareness that you have leaked urine? ☐ Yes ☐ No

Please **CHECK** if you experience a leakage of urine with one of the following:

☐ Cough/Sneeze/Laugh ☐ Exercise ☐ Intercourse ☐ Lying Down ☐ Running
☐ Sitting ☐ Straining/Lifting ☐ Urgency ☐ Walking

Please **CIRCLE** the amount of leaking you experience:

Drops More than Drops Flood Leak Continuously

Do you wear any protection (pads/liners) for urine leakage? ☐ Yes ☐ No

If yes, how many? ___________

Do you ever wake up in the middle of the night, having wet the bed? ☐ Yes ☐ No

Bowel Health History

How often do you have a bowel movement? _________ times per day; ________ times per week

Please **CIRCLE** if you are experiencing the following:

Constipation Diarrhea Incontinence Increased Fiber Use
Laxative Use Leaking Gas Stool Softener Use

Do you experience bowel urgency (quick onset/urge to pass stool?) ☐ Yes ☐ No

Do you have pain when having a bowel movement? ☐ Yes ☐ No

Do you have to strain to have a bowel movement? ☐ Yes ☐ No

Please **CIRCLE** your most common stool consistency:

Liquid Soft Firm Pellets Other (please describe): ______________________

If you are experiencing bowel leakage, please answer the following questions; if not, please skip this section:

Do you experience any bowel leakage? ☐ Yes ☐ No

Do you have sensation/awareness that you have leaked stool? ☐ Yes ☐ No

Sexual Health History

Do you experience any pain with intercourse? ☐ Yes ☐ No

If you are experiencing pain with intercourse, please answer the following questions; if not, please skip this section:

Do you experience pain with initial or deep penetration? ☐ Initial ☐ Deep ☐ Both

Is the pain you are experiencing during intercourse or after intercourse? ☐ During ☐ After ☐ Both

Is the pain positional, that is, the pain changes with position changes? ☐ Yes ☐ No

Is your partner understanding of your pain with intercourse? ☐ Yes ☐ No

Please **CHECK** the pain you are experiencing with intercourse:

☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Sore ☐ Throbbing
☐ Tight ☐ Tingly ☐ Other (please briefly describe): ______________________________

Please describe any other pain associated with intercourse that you are experiencing: ______________________
____