General Pelvic Health 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.

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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: ______________________________

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Flip Over

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) ______________________________

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

Date of Last Pap Smear:	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): __________________________

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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: ___________________________

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