



# 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:

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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:

- |   |                                     |  |  |
|---|-------------------------------------|--|--|
| <input type="checkbox"/> Abdominal Pain                         | <input type="checkbox"/> Groin Pain | <input type="checkbox"/> Hip Pain      | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Pelvic Pain                            | <input type="checkbox"/> Pubic Pain | <input type="checkbox"/> SI Joint Pain | <input type="checkbox"/> <b>NONE</b>   |
| <input type="checkbox"/> Other (please briefly describe): _____ |                                     |  |  |

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

- |   |                                   |                               |                                    |                                |
|---|-----------------------------------|-------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Aching                                 | <input type="checkbox"/> Burning  | <input type="checkbox"/> Deep | <input type="checkbox"/> Dull      | <input type="checkbox"/> Numb  |
| <input type="checkbox"/> Sharp                                  | <input type="checkbox"/> Shooting | <input type="checkbox"/> Sore | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tight |
| <input type="checkbox"/> 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:

|  |   |   |  |   |   |          |          |          |          |           |
|--|---|---|--|---|---|----------|----------|----------|----------|-----------|
|  |  |  |  |  |  |          |          |          |          |           |
| <b>0</b>   | <b>1</b>  | <b>2</b>  | <b>3</b>   | <b>4</b>  | <b>5</b>  | <b>6</b> | <b>7</b> | <b>8</b> | <b>9</b> | <b>10</b> |
| <b>No Hurt</b>   | <b>Hurts Little Bit</b>   | <b>Hurts Little More</b>  | <b>Hurts Even More</b>   | <b>Hurts Whole Lot</b>  | <b>Hurts Worst</b>  |          |          |          |          |           |

### 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): \_\_\_\_\_

### 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

Next Page 

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: \_\_\_\_\_

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