



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
- | | |
|--|---|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> Walking greater than _____ minutes | <input type="checkbox"/> With laughing/yelling |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> Changing positions (i.e. - sit to stand) | <input type="checkbox"/> With cold weather |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> With triggers -running water/key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> 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 _____ | | |



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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/prostate |
| 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 (Females only)

- | | |
|---|---------------------------------|
| 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 _____

Males only

- | | |
|------------------------|--------------------------|
| Y/N Prostate disorders | Y/N Erectile dysfunction |
| Y/N Shy bladder | Y/N Painful ejaculation |
| Y/N Pelvic pain | |
- Y/N Other /describe _____

<u>Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____



Name _____

<u>Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>

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	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
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 |



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Name _____

10a. On average, how much urine do you leak?

- No leakage
- Just a few drops
- Wets underwear
- Wets outerwear
- Wets the floor

10b. How much stool do you lose?

- No leakage
- Stool staining
- Small amount in underwear
- Complete emptying

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