Pelvic Floor Patient History

Name: **Date:**

1. Describe the current problem that brought you here?

2. When did your symptoms start?

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe incident if applicable:

4. If pain is present, rate pain on a 0-10 scale 10 being the worst.
Describe the nature of the pain (burning, aching, sharp, stabbing)

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Recurrent bladder infections
Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Frequent urination at night
Y/N Other/describe

5. 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

6. The usual amount of urine passed is: ___small ___ medium___ large.

Medications:

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****Skip section if no leakage/incontinence**

7a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

7b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

8a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear

8b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

9. Activities/events that cause or aggravate your symptoms. **Check/circle all that apply:**
___ Sitting
___ Walking
___ Standing
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list
___ Cough/sneeze/straining
___ Laughing/yelling
___ Lifting/bending
___ Cold weather
___ Triggers -running water/key in door
___ Nervousness/anxiety
___ No activity affects the problem

10. What relieves your symptoms?

11. How has your lifestyle/quality of life been altered/changed because of this problem?

12. **Since the onset of your current symptoms, have you had any further symptoms:**

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		

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

13. **Have you ever had any of the following conditions or diagnoses?** **<u>Circle all that apply</u>**

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:

14. **<u>Ob/Gyn History (females only)</u>**

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

<u>Males only</u>

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

Patient signature ________________ Therapist signature ______________ Date __________