

## PATIENT PELVIC QUESTIONNAIRE / HEALTH HISTORY

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.*

### HISTORY OF PRESENT CONDITION

Describe your main problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_  
 \_\_\_\_\_

Which of the following **best describes** how your injury occurred?

- |   |   |
|---|---|
| <input type="checkbox"/> (1) childbirth               | <input type="checkbox"/> (7) car accident |
| <input type="checkbox"/> (2) after surgery            | <input type="checkbox"/> (8) trauma       |
| <input type="checkbox"/> (3) a fall                   | <input type="checkbox"/> (9) running      |
| <input type="checkbox"/> (4) lifting                  | <input type="checkbox"/> (10) unknown     |
| <input type="checkbox"/> (5) degenerative process     | <input type="checkbox"/> (11) other _____ |
| <input type="checkbox"/> (6) during recreation/sports |   |

Since onset, are your symptoms getting: (Check one)

- (1) better     (2) worse     (3) not changing

Which of the following best describes the nature of your symptoms? (Check all that apply)

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> (1) sharp    | <input type="checkbox"/> (7) throbbing    | <input type="checkbox"/> (13) aching      |
| <input type="checkbox"/> (2) stabbing | <input type="checkbox"/> (8) splitting    | <input type="checkbox"/> (14) occasional  |
| <input type="checkbox"/> (3) constant | <input type="checkbox"/> (9) cramping     | <input type="checkbox"/> (15) n/a         |
| <input type="checkbox"/> (4) dull     | <input type="checkbox"/> (10) itching     | <input type="checkbox"/> (16) other _____ |
| <input type="checkbox"/> (5) shooting | <input type="checkbox"/> (11) tender      |   |
| <input type="checkbox"/> (6) gnawing  | <input type="checkbox"/> (12) hot/burning |   |

Describe activities that you cannot do because of your problem  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Last Pelvic Exam (date) \_\_\_\_\_

Last Urinalysis (date) \_\_\_\_\_

Other Special Tests (Specify date, type, results) \_\_\_\_\_  
 \_\_\_\_\_

Are you sexually active?  (1) No     (2) Yes

Pain or problems with sexual activity? \_\_\_\_\_

History of/or present sexually transmitted diseases?

(1) No     (2) Yes Type: \_\_\_\_\_

**WOMEN** -- Are you pregnant or attempting pregnancy?

(1) No     (2) Yes

# of vaginal deliveries \_\_\_\_\_ # of Cesarean deliveries \_\_\_\_\_

Complications from childbirth? \_\_\_\_\_  
 \_\_\_\_\_

Do you have any of the following (check all that apply)

- (1) difficulty initiating a stream/bowel movement
- (2) no perception of bladder fullness
- (3) weak, slow or intermittent stream of urine
- (4) frequent toileting to avoid problems
- (5) dribbling after stream ends
- (6) pain/burning during urination/defecation
- (7) blood in stool/urine
- (8) n/a

1. Occurrence of incontinence or leakage (if this does not apply skip to question #4)

- (1) times a day \_\_\_\_\_     (2) times a week \_\_\_\_\_  
 (3) times a month \_\_\_\_\_

2. Severity of Leakage

- (1) no leakage     (4) wet outerwear  
 (2) few drops     (5) other \_\_\_\_\_  
 (3) wet underwear

3. Position or activity with leakage

- |  |  |
|--|--|
| <input type="checkbox"/> (1) no leakage  | <input type="checkbox"/> (8) coughing            |
| <input type="checkbox"/> (2) lying down  | <input type="checkbox"/> (9) sneezing            |
| <input type="checkbox"/> (3) sitting     | <input type="checkbox"/> (10) laughing           |
| <input type="checkbox"/> (4) standing    | <input type="checkbox"/> (11) changing positions |
| <input type="checkbox"/> (5) walking     | <input type="checkbox"/> (12) sexual act         |
| <input type="checkbox"/> (6) running     | <input type="checkbox"/> (13) when constipated   |
| <input type="checkbox"/> (7) strong urge | <input type="checkbox"/> (14) on way to toilet   |

4. Prolapse (feeling of falling out)

- (1) never     (4) pressure with straining  
 (2) occasionally/with menses     (5) pressure with standing  
 (3) pressure at end of day     (6) pressure all day

5. How long can you delay the need to eliminate?

(A) Bowel     (B) Bladder

- |   |   |
|---|---|
| <input type="checkbox"/> (1) indefinitely | <input type="checkbox"/> (5) less than 10 minutes |
| <input type="checkbox"/> (2) 1+ hours     | <input type="checkbox"/> (6) 1-2 minutes          |
| <input type="checkbox"/> (3) 1/2 hour     | <input type="checkbox"/> (7) not at all           |
| <input type="checkbox"/> (4) 15 minutes   |   |

6. Ability to stop urine flow

- (1) can stop completely  
 (2) can maintain a deflection of the stream  
 (3) can partially deflect urine stream  
 (4) unable to deflect or slow the stream  
 (5) other \_\_\_\_\_

7. Fluid Intake \_\_\_\_\_ 8 oz. glasses per day  
 Caffeinated beverages \_\_\_\_\_ glasses per day

8. Frequency of bowel movements \_\_\_\_\_ times per week

9. If you are experiencing pain, do your symptoms wake you at night?  (1) No     (2) Yes     (3) N/A  
 if "yes", is it present

- (1) while lying still     (2) changing positions     (3) both

10. What aggravates your symptoms? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> (1) sitting                   | <input type="checkbox"/> (11) menstruation          |
| <input type="checkbox"/> (2) squatting                 | <input type="checkbox"/> (12) sustained bending     |
| <input type="checkbox"/> (3) standing                  | <input type="checkbox"/> (13) taking a deep breath  |
| <input type="checkbox"/> (4) sleeping                  | <input type="checkbox"/> (14) going to/from sitting |
| <input type="checkbox"/> (5) sexual activity           | <input type="checkbox"/> (15) coughing/sneezing     |
| <input type="checkbox"/> (6) lying                     | <input type="checkbox"/> (16) stress                |
| <input type="checkbox"/> (7) walking                   | <input type="checkbox"/> (17) not applicable        |
| <input type="checkbox"/> (8) exercises including _____ | <input type="checkbox"/> (18) other _____           |

(9) repetitive activities including \_\_\_\_\_

11. What relieves your symptoms? (Check all that apply)
- (1) sitting
  - (2) heat
  - (3) cold
  - (4) stretching
  - (5) rising from sitting
  - (6) rest
  - (7) standing
  - (8) walking
  - (9) exercise
  - (10) lying down
  - (11) massage
  - (12) medication
  - (13) nothing
  - (14) other \_\_\_\_\_

12. Have you had any previous treatment for this condition? (Check all that apply)
- (1) none
  - (2) laser
  - (3) TENS unit
  - (4) surgery
  - (5) dietary changes
  - (6) physical therapy
  - (7) electrical stimulation
  - (8) injection into the skin/muscles
  - (9) pelvic floor exercises
  - (10) biofeedback
  - (11) joint manipulation
  - (12) ultrasound
  - (13) injection into the spine
  - (14) overnight hospitalization
  - (15) other \_\_\_\_\_

Any other concerns not addressed? \_\_\_\_\_

### MEDICATION

In the last 4 weeks have you taken any medication for your current symptoms?  (1) Yes  (2) No

List: \_\_\_\_\_

Please list any other prescription medications you are currently taking (*pain pills, injections and/or skin patches etc.*):

\_\_\_\_\_

Are you currently taking any of the following over the counter medications?

- (1) aspirin
- (2) Tylenol
- (3) corticosteroids
- (4) antihistamines
- (5) Vitamins/mineral supplements
- (6) Advil/Motrin/Ibuprofen
- (7) other \_\_\_\_\_

### PREVIOUS FUNCTIONAL LEVEL

**Independent in all activities** (work, community, home, recreation)

#### Self Care

- Independent in all self-care (bathing, toileting, dressing, etc.) activities
- Have difficulty performing self-care activities
- Need assistance with self-care activities
- Have difficulty performing household chores

#### Social

Need assistance with activities in community outside of home

Hobbies: \_\_\_\_\_

### WORK HISTORY

#### Occupation

- (1) employed full time
- (2) employed part time
- (3) self employed
- (4) homemaker
- (5) student
- (6) retired
- (7) unemployed
- (8) other \_\_\_\_\_

#### Physical activities at work

- (1) sitting
- (2) heavy lifting
- (3) repetitive lifting
- (4) computer use
- (5) heavy equipment operation
- (6) driving
- (7) other \_\_\_\_\_

Are you currently receiving for seeking disability for this condition?

Yes  No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?  Yes  No

### LIVING SITUATION

- live alone
- live with caregiver
- live with family member/others
- home/apartment
- retirement complex (SNF/ ICF)
- assisted living complex
- other \_\_\_\_\_

#### Setting

- stairs
- uneven ground
- stairs with railing
- ramp
- elevator
- other \_\_\_\_\_

### GENERAL HEALTH

How would you rate your general health?

- Excellent
- Good
- Average
- Fair
- Poor

Do you exercise outside of normal daily activities?

- (1) 5+days/wk
- (2) 3-4 days/wk
- (3) 1-2days/wk
- (4) occasionally
- (5) zero

Exercise consisting of \_\_\_\_\_

Do you smoke?

- No
- Yes \_\_\_\_\_ packs of cigarettes a day

What is your stress level?

- Low
- Medium
- High

Are you seeing any health care providers other than the physical therapist for this current condition?(list) \_\_\_\_\_

### MEDICAL HISTORY

Have you ever had/ been diagnosed with any of the following conditions?

- Cancer (type) \_\_\_\_\_
- Depression
- Stroke
- Kidney Problems
- Thyroid problems
- Diabetes
- Multiple Sclerosis
- Arthritis
- Head Injury
- Circulation/vascular problems
- Parkinson's Disease
- Infectious Diseases (i.e. hepatitis, tuberculosis)
- Heart Problems
- High blood pressure
- Lung Problems
- Blood Disorders
- Epilepsy/Seizures
- Allergies
- Rheumatoid arthritis
- Osteoporosis
- Broken bone
- Stomach problems
- Other \_\_\_\_\_

List pelvic/abdominal or bowel/bladder surgeries with dates of operation

SURGERY

DATE

### FAMILY HISTORY

Has anyone in your immediate family (*parents, brothers, sisters*) ever been treated for any of the following?

- Diabetes
- Heart disease
- High blood pressure
- Stroke
- Other \_\_\_\_\_
- Cancer
- Arthritis
- Osteoporosis
- Psychological Condition