PELVIC HEALTH INTAKE FORM-1

Name:_________________________________ Age:________ Occupation:____________________________

1. GENERAL MEDICAL HISTORY

Date of injury: ______________ Date of surgery: ____________ Date of last Physical: ______________

Medical History: (circle all that apply)

Cancer *type* _____________	Osteoarthritis	Frequent/Severe Headaches
Diabetes *type* ____________	Osteoporosis	Blood Clot
High Blood Pressure	Rheumatoid Arthritis	Seizures/Epilepsy
Heart Disease	Autoimmune Disease	Kidney Disease
Heart Attack	Hyper/Hypothyroidism	GERD/Ulcers
Angina/Chest Pain	HIV, HEP B, HEP C	Emphysema/COPD
Stroke/TIA	Tuberculosis	Multiple Sclerosis/Parkinson's
Sexually Transmitted Infection	Bleeding Disorder	Anemia
Other:____________________		

In the past year have you had:

Falls *how many*_____	Dizziness/fainting	Nausea/vomiting
Double vision	Unexplained Weight Change	Difficulty sleeping
Fever/Chills/Sweats	Difficulty Swallowing	A motor vehicle/workplace accident

Do you drink alcohol? Yes/No If yes, how many drinks per week: ______________________________

Do you or have you ever smoked or used tobacco products? Yes/No

If yes do you smoke cigarettes, vape, chew or other? ________________________________

How many ________ packs x ____________ years. Date of last tobacco use. _______________

Have you had any recent x-rays, MRI, CT, Nerve Conduction Studies? If so what did they show?

____

Please list any surgeries with dates of surgery if possible:

____

____

2. URINARY FUNCTION *(Please circle all that apply)*:

Please estimate how often you urinate: day_______times night________times

How many pads/diapers do you use per day? ______pads/diapers

Do you leak urine Yes / No Do you experience a strong urge to urinate? Yes / No

Do you leak urine or experience a strong urge to urinate with any of these activities?

Cough / Sneeze / Yell / Jump / Exercise / Laugh / Change body position / Other______________________

Key in the door / Running water / Cold / Getting to the bathroom / Constantly leak

Do you have difficulty starting the flow of urine? Yes / No

Do you have to strain to fully empty your bladder? Yes / No

Do you fully empty your bladder when you urinate? Yes / No

3. BOWEL FUNCTION *(Please circle all that apply)*:

Please estimate how often you have a bowel movement: day:____times night:_____times

Do you leak gas/stool? Yes / No Do you experience a strong urge to have a bowel movement? Yes / No

How many pads/diapers do you use per day? ______pads / diapers

Do you leak gas/stool or experience a strong urge to have a bowel movement with any of these activities?

Cough / Sneeze / Yell / Jump / Exercise / Laugh / Change body position / Other______________________

Key in the door / Running water / Cold / Getting to the bathroom

Do you have to strain to have a bowel movement? Yes / No

Do you experience constipation? Yes / No

Do you have difficulty fully emptying your bowel? Yes / No

4.NUTRITION/FLUID INTAKE /EXERCISE:

How much fluid do you drink during the day? Water________oz Other_______oz Alcohol________oz

How often do you exercise? ________/week

Do you have/ had an eating disorder: anorexia / bulimia / other_______________________________________.

5. GYNECOLOGICAL HISTORY *(Please circle all that apply)*:

The first day of my last menstrual cycle was: _______________/ I have not started my menstrual cycle yet.

If still menstruating, periods are: light / moderate / heavy / bleed through protection

Do you have a history of or currently have feelings of: pelvic heaviness / fibroids / cysts / endometriosis

6. OBSTETRIC HISTORY *(Please circle all that apply)*:

Are you or have you ever been pregnant? Yes / No If no, please skip to next section

Are you currently pregnant? Yes / No

I am at ________weeks gestation, with the due date of ___________.

Has your physician placed you on any restrictions? No / Yes If yes, please specify: _______________

Number of pregnancies_______. Number of vaginal deliveries______. Number of cesarean deliveries______.

Number of episiotomies_____. Number of miscarriages_____. Date(s):________________________________

Birth weights:____

Did you have any complications during pregnancy, labor, delivery or post-partum? (*Please circle)*

vacuum / post-partum hemorrhaging / forceps / medication for bleeding / post-partum depression

pre-eclampsia / other ____

7. PAIN HISTORY *(Please circle all that apply)*:

Do you have problems with pain? Yes / No Are you sexually active at this time? Yes / No

Are you sexually inactive due to pain? Yes / No Are you sexually inactive for other reasons? Yes / No

Do you have pain: during ovulation / just before your period

Do you have pain with intercourse? Yes / No

If yes, please circle: close to the vaginal opening / deep inside / with orgasm / other _____________________

Do you have pain after intercourse? Yes / No

If yes, please circle: full bladder / muscle or joint pain / burning vaginal pain / pain with urination / backache / migraine / pain with sitting / other____

IN THE LAST 7 DAYS:

I have blamed myself unnecessarily when things went wrong.	I have felt panicky or scared for no very good reason.	I have been anxious or worried for no good reason.
Yes, all the time Yes, most of the time No, not very often No, not at all	Yes, all the time Yes, most of the time No, not very often No, not at all	Yes, all the time Yes, most of the time No, not very often No, not at all