PELVIC HEALTH INTAKE FORM-2

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	Shy bladder	Prostate problems
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 or have you ever experienced 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. 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 erection? Yes / No

Do you have pain during ejaculation? Yes / No

Where is your pain located?

rectal area / penis / testicles / behind testicle / buttock / abdomen / feels deep / other_____

Do you have pain after intercourse? Yes / No

If yes, please circle: with full bladder / muscle or joint pain / with urination / backache / migraine headache 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, all the time	Yes, all the time
Yes, most of the time	Yes, most of the time	Yes, most of the time
No, not very often	No, not very often	No, not very often
No, not at all	No, not at all	No, not at all