Ferrell-Whited Physical Therapy Services

3780 Medina Road, Suite 300
330-952-1882

Women's Health Patient History

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 the 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
___Sitting greater than ______minutes
___Walking greater than ______minutes
___Standing greater than ______ minutes
___Changing positions (i.e. – sit to stand)
___Light activity (light housework)
___Vigorous activity/exercise (run/weight lift/jump)
___Sexual activity
___ With cough / sneeze / straining
___ With laughing / yelling
___ With lifting / bending
___ With cold weather
___ With triggers – running water / key in door
___ With nervousness / anxiety
___ No activity effects the problem
Other, please list ____

8. What relieves your symptoms? ____
____

9. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst________________________

10. What are your treatment goals / concerns?____

Since the onset of your current symptoms have you had:

Y/N Fever / Chills

Y/N Unexplained weight change

Y/N Dizziness or fainting

Y/N Change in bowel or bladder functions

Y/N Malaise (Unexplained tiredness)

Y/N Unexplained muscle weakness

Y/N Night pain / sweats

Y/N Numbness / Tingling

Y/N Other / describe____

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History:

Health history:

Date of last internal pelvic exam________________________________

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 psychological therapy? Yes / No

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.

Alcoholism / Drug problems	Ankle swelling	Anorexia / Bulimia
Childhood bladder problems	Chronic Fatigue Syndrome	Fibromyalgia
Headaches	Head Injury	Hearing loss / problems
Hepatitis HIV/AIDS	Hypothyroid / Hyperthyroid	Irritable Bowel Syndrome
Joint Replacement	Kidney Disease	Latex sensitivity
Low back pain	Pelvic pain	Physical or sexual abuse
Sacroiliac / Tailbone pain	Sexually transmitted disease	Smoking history
Sports injuries	Stress fractures	TMJ/ neck pain
Raynaud's (cold hands and feet)		

Other / describe____

Latex allergy? Yes No

Intrauterine Device? Yes No

Pacemaker / Defibrillator? Yes No

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Surgical / Procedure History:

Y / N Surgery for your back / spine

Y / N Surgery for your bladder

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:

Y / N Childbirth vaginal deliveries # _______

Y / N C-Section # _______

Y / N Difficult childbirth # _______

Y/ N Episiotomy or tearing # _______

Y / N Vaginal dryness

Y / N Painful periods

Y / N Menopause – when? _______

Y / N Painful vaginal penetration

Y / N Prolapse or organ falling out

Y / N Pelvic pain

Y / N Other / describe: ____

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Symptoms

Pelvic Symptom Questionnaire

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 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 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" / prolapsed 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

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Skip questions if no leakage / incontinence

9a. Bladder leakage – number of episodes

_______No leakage

_______Times per day

_______Times per week

_______Times per month

_______Only with physical exertion / cough?

9b. Bowel leakage – number of episodes

_______No leakage

_______Times per day

_______Times per week

_______Times per month

_______Only with exertion

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

_______No leakage

_______Just a few drops

_______Wets underwear

_______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, maxi pad)

_______Maximum protection (Specialty product / diaper)

_______Other____

On average, how many pad/production changes are required before 24 hours? _______ # of pads

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