

PATIENT QUESTIONNAIRE: FEMALE PELVIC FLOOR

Name: _____ Age: _____ DOB: _____

Referring Doctor: _____ Diagnosis: _____

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date): _____

Have you received other treatment for this problem? No OR Yes: (type) _____

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / osteoporosis
thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis
rheumatoid arthritis / seizures / history of stroke / kidney problems / depression / hx of blood clots/DVT
Other: _____

Surgical History (list type & date): _____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages _____
Number of pregnancies _____ . Number of vaginal deliveries _____ . Number of C-sections _____
Birthdates & weight of each baby: _____
History of sexually transmitted diseases: No OR Yes: (specify active infections) _____
History of chronic urinary / bladder / yeast infections? No OR Yes: (specify) _____
Any active infections at this time? No OR Yes: (specify type/treatment) _____
Approximate date last menstrual cycle: _____ Menopausal? No OR Yes(hormone replacement? _____)
(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Current Medications: _____

Allergies: _____

Work Status: currently working retired temporarily off work unemployed other:

Location / type of work: _____

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Emergency Contact:

Name: _____ Daytime phone #: (____) _____ - _____

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How did you learn about us? friend physician internet advertisement other:

Date of your next doctor's appointment: _____

Patient's Signature

Date

Urinary Symptoms: Check all that apply and fill in appropriate blanks.

- Urgency: abnormally strong urges to urinate
- Frequency: urinates _____ times per (circle one) hour / day.
- Leaking: When I leak, it (circle all that apply)
dampens underwear / dampens outerwear / empties my bladder completely.
- Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing
laughing / sneezing / bending / standing up / opening door to house / parking car
on way to bathroom / walking / jogging/exercise / sexual intercourse / hear running water
other: _____
- Leaking: I leak _____ times a (circle one) day / week.
- Use of leakage protection (number per day): panty liner _____ / pad _____ / diaper _____
- Wake at night to urinate: number of times each night: _____
- Burning with urination
- Abnormal stream (specify: _____)
- Difficulty or hesitancy with emptying bladder

Other: _____

Fluid Intake: Fill in average number of cups (1 cup=8 ounces) of each for a normal day:

- Water Milk Juice (specify: _____)
- Soft Drinks Decaf Soft Drinks Tea
- Decaf Tea Coffee Decaf Coffee
- Alcohol Other: _____

Bowel Symptoms: Check all that apply and fill in blanks.

Number of bowel movements per (circle one) day / week : _____

- Constipation: I frequently strain to move bowels because of this: Yes OR No
- Take regular fiber supplements (type and frequency): _____
- Frequent diarrhea
- Irritable bowel syndrome
- Lactose intolerance or other food allergy affecting bowels (specify other: _____)
- Bowel leakage (circle all that apply): stains underwear / small amount / large amount
- Bowel leakage (circle all that apply): I leak with lifting / coughing / laughing / sneezing /
bending / standing up / walking / jogging/exercise / sexual intercourse
other: _____
- Bowel leakage: I leak _____ times a (circle one) day / week.
- Use of leakage protection (number per day): panty liner _____ / pad _____ / diaper _____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages _____

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(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Goals you want to achieve through therapy (be specific): _____
