Patient Questionnaire for Women

Please fill out the following questionnaire to the best of your ability prior to your first appointment. Your physical therapist will review your responses during your initial visit.

Patient Name Date					
Name of primary car					
Referred to Physical	Therapy	by:			
What is the reason f	or your	visit?			
How did you hear a website; phone book;		nmin Physical Thera		al; word of moutl	1;
Gynecologic History	V			Circle Yes or	No
1. Have you eve If yes, please		regnant? ber of pregnancies/de	eliveries:	Y	N
	eight oaby	Vaginal or Cesarean Delivery	Episiotomies (Y/N)	Tears or Complication	ıs?
2. Are you tryin	σ to get	nreonant?		Y	N
3. Did you have		-			N
4. Did you have	any pro	longed labors or com	plications giving bi	rth? Y	N
5. Did you have	complic	cations during the pre	gnancy?	Y	N
6. Were forceps or a vacuum extraction used during pregnancy?			Y	N	
7. Date of last p	eriod				
8. Do you have:	regular 1	menstrual cycles?		Y	N

9. Do you have pain with menstruation?			Y	N
10. Do you take oral contraceptives (birth control pills)?			Y	N
11. Form of Birth Control:				
12. Have you reached Menopause?				N
If yes, are you taking Estrogen Therapy?			Y	N
13. Date of your last pap smear				
14. Have you ever had an abnormal pap smear?			Y	N
15. Have you had a hysterectomy? If so, at what age?			Y	N
Were your ovaries removed?			Y	N
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16. Have you had a Mammogram			Y	N
If so, when was your last one?				
Medical History/Family History				
Do you are any of your relatives have a history of the following	1	~9		
Do you or any of your relatives have a history of the fol		_	(relation to	von)
		Relative	(relation to	
Anemia	You	Relative		
	You	Relative		
Anemia Bleeding tendency Cancer	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble	You	Relative		
Anemia Bleeding tendency Cancer	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis Lung Disease/Asthma	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis Lung Disease/Asthma Migraine Headaches	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis Lung Disease/Asthma Migraine Headaches Osteoporosis	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis Lung Disease/Asthma Migraine Headaches Osteoporosis Psychiatric disorder Seizures/Epilepsy Thyroid Disease	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis Lung Disease/Asthma Migraine Headaches Osteoporosis Psychiatric disorder Seizures/Epilepsy Thyroid Disease Stroke	<u>You</u>	Relative		
Anemia Bleeding tendency Cancer Colitis/Bowel trouble Depression Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Liver disease/Hepatitis Lung Disease/Asthma Migraine Headaches Osteoporosis Psychiatric disorder Seizures/Epilepsy Thyroid Disease	<u>You</u>	Relative		

Other:	
Have you had any previous fractures?	Y N
Any other serious injuries? Have you had any blood transfusions?	Y N Y N
Surgical history:	
Please list any surgeries not mentioned pro	eviously in this questionnaire:
Surgical procedure	Date
Medications	
List medications or supplements you are c	currently taking:
List any drug allergies:	
Are you allergic to latex:	Y N
Bladder Symptoms	Circle Yes or No
1. Have you ever filled out a bladder	diary? Y N
2. Do you have frequent urinary tract	infections? Y N
3. Please circle your urgency on a da	ily basis.
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4.	Do you lose urine when you cough/sneeze/laugh?	Y	N
5.	Do you lose urine during physical activity like running, jumping, lifting?	Y	N
6.	If you lose urine, how much do you leak? circle one: small, medium, large	e	
7.	Do you ever have strong, uncontrolled urges to urinate? If so, how many times per day	Y	N
8.	Do you ever lose urine because you cannot make it to the bathroom in tim	ie?Y	N
9.	How many times do you urinate (void) throughout the day?		
10.	How many times do you void at night?		
11.	Does your bladder wake you up at night?	Y	N
12.	How large are your voids? circle one: small, medium, or large		
13.	Do you strain to urinate or empty your bladder?	Y	N
14.	Do you have difficulty starting a stream of urine?	Y	N
15.	Do you have a slow or weak flow?	Y	N
16.	Do you have splitting of the stream or dribbling?	Y	N
17.	Do you feel like you empty your bladder completely after urination?	Y	N
18.	Do you have pain before, during or after urination? (circle all that apply)		
19.	Do you have pain or burning with urination?	Y	N
20.	Do you have blood in your urine?	Y	N
21.	Do you wear a pad for leakage? If so, how many times do you change the pad daily?	Y	N
22.	Do you ever feel bulging or a feeling of "falling out" in your vagina?	Y	N
23.	How much fluid do you drink per day?		
24.	Do you drink caffeinated beverages regularly?	Y	N

25. Do you drink alcohol regularly?

Y N

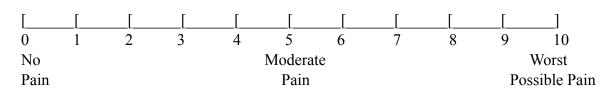
Bowel Symptoms Circ			·No
1.	How often do your move your bowels per day? week?		
2.	Do you have pain before, during or after a bowel movement? (circle all the	at ap	oply)
3.	Do you have constipation?	Y	N
4.	Do you strain/push out with bowel movements?	Y	N
5.	Do you have pain with bowel movements?	Y	N
6.	Do you have blood in your stools?	Y	N
7.	Do you often have diarrhea?	Y	N
8.	Do you leak and stain your underwear with feces?	Y	N
9.	Can you tell the difference between a bowel movement and passing gas?	Y	N
10	. Most common stool consistency? circle one: liquid, soft, firm, pellets, or o	othe	r
Pain S	Symptoms Circle Ye	s or	·No
1.	Do you have pain with the insertion of a speculum during a pelvic exam?	Y	N
2.	Do you have pain with the use of tampons?	Y	N
3.	Do you have pain in the area between the rectum and vagina?	Y	N
4.	Do you have pain in the genital/vaginal area?	Y	N
5.	Do you experience abdominal pain?	Y	N
6.	Do you have a history of back pain?	Y	N
7.	Do you have head/neck pain?	Y	N
8.	Do you clench your teeth or have jaw pain?	Y	N

9. Do you have a history of headaches/migraines?

Y N

10. List any other areas of pain

Please circle the level/number of pain you experience on a daily basis:



Sexual History

Circle Yes or No

1. Are you currently sexually active?

Y N

2. Do you have a desire to be sexually active?

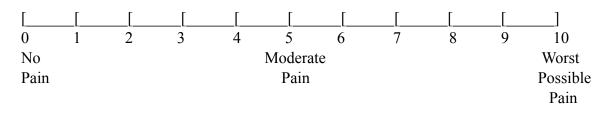
Y N

- 3. What is your sexual preference? *Circle one*: Male, Female, Both
- 4. Do you have pain with sexual intercourse?

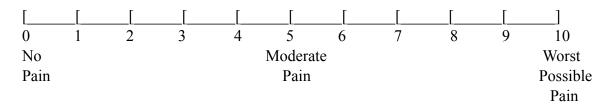
Y N

If yes, describe the pain felt during sexual intercourse: burning, throbbing, stabbing, other _____

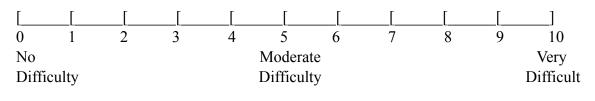
5. Do you have pain with initial penetration? If so, please circle your level of pain



6. Do you have pain with deep penetration? If so, please circle your level of pain



7. Do you have difficulty with climax/orgasm? If so, please circle your level of difficulty



- 8. Do you have pain with orgasm? Y N
- 9. Do you ever lose urine during sexual intercourse? Y N
- 10. Do you ever have bowel incontinence during sexual intercourse? Y N
- 11. Do you have a history of physical, mental or sexual abuse? Y N
- 12. Do you have a history of sexually transmitted diseases? Y N If yes, please describe

Lifestyle Circle Yes or No

- 1. Do you have a balanced diet? Y N
- 2. Are there foods in your diet that aggravate your symptoms? _____
- 3. What is your occupation?
- 4. Do you spend long hours driving each day?
- 5. Do you stand or sit for long periods each day?

 Y N
- 6. Have you ever fallen on/broken your tailbone? Y N
- 7. Do you exercise? Y N

 If so, how many times per week
- 8. Do you smoke? Y N

 If yes, how many packs per day
- 9. Do you use recreational drugs?
- 10. Do your symptoms impact your social life? Y N

11. Do your symptoms make you sad or depressed?	Y	N
12. Do your symptoms interfere with family or household responsibilities?	Y	N
Sleeping patterns: Circle Y		No
1. How many hours of sleep do you get nightly?		
2. Do you wake up after a night's sleep feeling rested?	Y	N
3. How many hours of sleep do you need to feel rested?		
4. Do you have difficulty falling asleep?	Y	N
5. Do you drink caffeine or alcohol within three hours before bedtime?	Y	N
6. Do you have night sweats?	Y	N
7. Are you a restless sleeper?	Y	N
8. Do you wake up in the morning with headaches?	Y	N
9. What is your usual sleep position?		
10. Do you often remember dreaming?	Y	N
11. Does your partner keep you awake by their sleeping habits?	Y	N
12. Do you snore?	Y	N
13. Do you have a hard time breathing when you sleep?	Y	N
List any additional comments or concerns that were not addressed in the questio	nnair	e:

Thank you for your time, please contact Kamin Physical Therapy at (847) 384-6804 with any further questions or concerns.