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 care physician _____
Referred to Physical Therapy by:
_____

What is the reason for your visit? _____
_____

How did you hear about Kamin Physical Therapy? doctor's referral; word of mouth; website; phone book; other: _____

Gynecologic History **Circle Yes or No**

1. Have you ever been pregnant? Y N
If yes, please list number of pregnancies/deliveries:

Date	Weight of baby	Vaginal or Cesarean Delivery	Episiotomies (Y/N)	Tears or Complications?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Are you trying to get pregnant? Y N

3. Did you have any elective cesareans? Y N

4. Did you have any prolonged labors or complications giving birth? Y N

5. Did you have complications during the pregnancy? Y N

6. Were forceps or a vacuum extraction used during pregnancy? Y N

7. Date of last period _____

8. Do you have regular 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? Y 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? Y N
    If so, at what age? _____
    Were your ovaries removed? Y N

16. Have you had a Mammogram Y N
    If so, when was your last one?_____

Medical History/Family History

Do you or any of your relatives have a history of the following?

	You	Relative	(relation to you)
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	____	_____	_____
Ulcers	____	_____	_____
Vein trouble/Blood clots	____	_____	_____

Other:_____

Have you had any previous fractures? Y N

Any other serious injuries? Y N
Have you had any blood transfusions? Y N

Surgical history:

Please list any surgeries not mentioned previously in this questionnaire:

Surgical procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications

List medications or supplements you are 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 daily basis.

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]
0 1 2 3 4 5 6 7 8 9 10
No Urge — Moderate Urge — Immediate Urge

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? c*ircle one*: small, medium, large

7. Do you ever have strong, uncontrolled urges to urinate? Y N
   If so, how many times per day _____
8. Do you ever lose urine because you cannot make it to the bathroom in time? 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? Y N
   If so, how many times do you change the pad daily? _____

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 **Circle Yes or 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 that apply)*
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? c*ircle one*: liquid, soft, firm, pellets, or other _____

Pain Symptoms **Circle Yes 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:

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]
0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

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

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]
0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

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

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]
0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

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

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]
0 1 2 3 4 5 6 7 8 9 10
No Difficulty — Moderate Difficulty — Very Difficult

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? Y N

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? Y N

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 Yes or 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 questionnaire:

_____
_____
_____
_____
_____

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