Pelvic History

Name ____DOB: _____________Age: _____

1. Describe the current problem that brought you here. ______________________
   ____
   ____
2. When did your problem first begin? _____ months ago or _____ years ago
3. 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 (ie. – 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 affects the problem
_____ Other, please list ____

4. What relieves your symptoms? ____
5. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify ____________________________________
Diet/Fluid intake, specify ____
Physical activity, specify ____
Work, specify ____

6. What are your treatment goals/concerns?_______________________________________
   ____
7. 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 ____
____

Date of Last Physical Exam _____ Tests Performed _________________________________

Date of Last Gynecological Exam _____

Have you ever had any of the following conditions or diagnoses? Check all that apply.

Y/N	Cancer	Y/N	Emphysema/chronic bronchitis	Y/N	Stroke
Y/N	Heart Problems	Y/N	Epilepsy/seizures	Y/N	Asthma
Y/N	High Blood Pressure	Y/N	Multiple Sclerosis	Y/N	Allergies-list below
Y/N	Ankle swelling	Y/N	Head injury	Y/N	Latex sensitivity
Y/N	Anemia	Y/N	Osteoporosis	Y/N	Hypothroid/Hyperthroid
Y/N	Low back pain	Y/N	Chronic Fatigue Syndrome	Y/N	Headaches
Y/N	Sacroiliac/Tailbone pan	Y/N	Fibromyalgia	Y/N	Diabetes
Y/N	Alcoholism/Drug Use	Y/N	Arthritic conditions	Y/N	Kidney disease
Y/N	Childhood bladder issue	Y/N	Stress fractures	Y/N	Irritable Bowel Syndrome
Y/N	Depression	Y/N	Rheumatoid Arthritis	Y/N	Hepatitis HIV/AIDS
Y/N	Anorexia/bulimia	Y/N	Joint Replacement	Y/N	Sexually Trans Disease
Y/N	Smoking/history	Y/N	Bone Fracture	Y/N	Physical/Sexual Abuse

Y/N Vision/eye problems
Y/N Hearing loss/problems
Y/N Sports Injuries
Y/N TMJ/neck pain
Y/N Raynaud's (cold hands/feet)
Y/N Pelvic pain
Other/Describe: ____

Surgical/Procedure History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/Describe: ____

OB/GYN History (females only)

Y/N Childbirth vaginal deliveries # _____
Y/N Episiotomy # _____
Y/N C-Section # _____
Y/N Difficult childbirth # _____
Y/N Pelvic pain
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause – when?
Y/N Painful vaginal penetration
Other/Describe: ____

Males only
Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Other/Describe: ____

Medications – pills, injection, patch   Start date   Reason for taking
____
____
____

Over the counter – vitamins, etc.   Start date   Reason for taking
____
____
____

Bladder/Bowel Habits/Problems

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 Dribbling after urination
Y/N Straining or pushing to empty bladder
Y/N Constant urine leakage
Y/N Trouble feeling bladder urge
Y/N Blood in urine
Y/N Painful urination
Y/N Constipation/straining
Y/N Current laxative use
Y/N Trouble emptying bladder completely
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections
Y/N Other/describe ____

1. Frequency of urination: How many times do you urinate during awake hours? _____
During the 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" / prolapse 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

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
____ Only with exertion

9b. Bowel leakage – number of episodes
_____ No leakage
_____ Times per day
_____ Times per week
____ Times per month
____ Only with physical exertion/cough
____ Only with exertion

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ 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, maxipad)
___Maximum protection (Specialty product/diaper)
___Other

12. On average, how many pad/protection changes are required in 24 hours? _____ # of pads

I hereby agree & give my consent to medical treatment in treating my physical condition. I give consent to Chautauqua Physical & Occupational Therapy (CPT) to use & disclose my protected health information with my referring physician & for purposes of treatment & payment. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes in my insurance. I authorize release of payment directly to CPT regardless of participation in or out-of-network. Should I default on my financial responsibility & collection action is necessary, I will be responsible for collection costs that are incurred. I give CPT permission to leave a message on my answering phone or with another party. I also give CPT permission to discuss my medical condition with another party. You have the right to review our posted Privacy Policy before you sign this consent. CPT reserves the right to amend the terms of our Privacy Policy at any time. I agree to & understand all of the above information.

Emergency Contact: ____

Phone: ___________________________ Relation: _______________________

Patient/Parent/Guardian Signature: _______________________________________Date:___________

Email Address: ____