

# 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                | _____ With cough/sneeze/straining               |
| _____ Walking greater than _____ minutes                | _____ With laughing/yelling                     |
| _____ Standing greater than _____ minutes               | _____ With lifting/bending                      |
| _____ Changing positions (ie. – sit to stand)           | _____ With cold weather                         |
| _____ Light activity (light housework)                  | _____ With triggers – running water/key in door |
| _____ Vigorous activity/exercise (run/weight lift/jump) | _____ With nervousness/anxiety                  |
| _____ Sexual activity                                   | _____ 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 Malaise (unexplained tiredness) |
| Y/N Unexplained weight change            | Y/N Unexplained muscle weakness     |
| Y/N Dizziness or fainting                | Y/N Night pain/sweats               |
| Y/N Change in bowel or bladder functions | 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 Hypothyroid/Hyperthyroid |
| Y/N Low back pain            | Y/N Chronic Fatigue Syndrome     | Y/N Headaches                |
| Y/N Sacroiliac/Tailbone pain | 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 Sports Injuries                      Y/N Raynaud's (cold hands/feet)  
 Y/N Hearing loss/problems                      Y/N TMJ/neck pain                      Y/N Pelvic pain

Other/Describe: \_\_\_\_\_

**Surgical/Procedure History**

Y/N Surgery for your back/spine                      Y/N Surgery for your bladder/prostate  
 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 (females only)**

Y/N Childbirth vaginal deliveries # \_\_\_\_\_                      Y/N Vaginal dryness  
 Y/N Episiotomy # \_\_\_\_\_                      Y/N Painful periods  
 Y/N C-Section # \_\_\_\_\_                      Y/N Menopause – when?  
 Y/N Difficult childbirth # \_\_\_\_\_                      Y/N Painful vaginal penetration  
 Y/N Pelvic pain

Other/Describe: \_\_\_\_\_

**Males only**

Y/N Prostate disorders                      Y/N Erectile dysfunction  
 Y/N Shy bladder                      Y/N Painful ejaculation  
 Y/N Pelvic pain

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 Blood in urine  
 Y/N Urinary intermittent /slow stream                      Y/N Painful urination  
 Y/N Trouble emptying bladder                      Y/N Constipation/straining  
 Y/N Difficulty stopping the urine stream                      Y/N Current laxative use  
 Y/N Dribbling after urination                      Y/N Trouble emptying bladder completely  
 Y/N Straining or pushing to empty bladder                      Y/N Trouble holding back gas/feces  
 Y/N Constant urine leakage                      Y/N Recurrent bladder infections  
 Y/N Trouble feeling bladder urge  
 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**

- |  |  |
|--|--|
| <p>9a. Bladder leakage – number of episodes</p> <p>___ No leakage<br/>       ___ Times per day<br/>       ___ Times per week<br/>       ___ Times per month<br/>       ___ Only with physical exertion/cough<br/>       ___ Only with exertion</p> | <p>9b. Bowel leakage – number of episodes</p> <p>___ No leakage<br/>       ___ Times per day<br/>       ___ Times per week<br/>       ___ Times per month<br/>       ___ Only with physical exertion/cough<br/>       ___ Only with exertion</p> |
|--|--|

- |   |   |
|---|---|
| <p>10a. On average, how much urine do you leak?</p> <p>___ No leakage<br/>       ___ Just a few drops<br/>       ___ Wets underwear<br/>       ___ Wets outerwear<br/>       ___ Wets the floor</p> | <p>10b. How much stool do you lose?</p> <p>___ No leakage<br/>       ___ Stool staining<br/>       ___ Small amount in underwear<br/>       ___ Complete emptying</p> |
|---|---|

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: \_\_\_\_\_

Revised: 9/4/18