Since 1952
Therapeutic Associates
PHYSICAL THERAPY

PATIENT PELVIC QUESTIONNAIRE / HEALTH HISTORY

NAME: _____ DATE:_____

To insure you receive a complete and thorough evaluation. please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

Describe your main problem? _____
_____
_____

When did your symptoms begin? _____
_____

Which of the following **best describes** how your injury occurred?
- ❒ (1) childbirth
- ❒ (2) after surgery
- ❒ (3) a fall
- ❒ (4) lifting
- ❒ (5) degenerative process
- ❒ (6) during recreation/sports
- ❒ (7) car accident
- ❒ (8) trauma
- ❒ (9) running
- ❒ (10) unknown
- ❒ (11) other _____

Since onset, are your symptoms getting: (Check one)
❒ (1) better ❒ (2) worse ❒ (3) not changing

Which of the following best describes the nature of your symptoms? (Check all that apply)
- ❒ (1) sharp
- ❒ (2) stabbing
- ❒ (3) constant
- ❒ (4) dull
- ❒ (5) shooting
- ❒ (6) gnawing
- ❒ (7) throbbing
- ❒ (8) splitting
- ❒ (9) cramping
- ❒ (10) itching
- ❒ (11) tender
- ❒ (12) hot/burning
- ❒ (13) aching
- ❒ (14) occasional
- ❒ (15) n/a
- ❒ (16) other _____ _____

Describe activities that you cannot do because of your problem
_____
_____
_____

Last Pelvic Exam (date)_____
Last Urinalysis (date)_____
Other Special Tests (Specify date, type, results) _____
_____

Are you sexually active? ❒ (1) No ❒ (2) Yes
Pain or problems with sexual activity? _____
History of/or present sexually transmitted diseases?
❒ (1) No ❒ (2) Yes Type:_____

WOMEN -- Are you pregnant or attempting pregnancy?
❒ (1) No ❒ (2) Yes
# of vaginal deliveries _____ # of Cesarean deliveries _____
Complications from childbirth? _____

Do you have any of the following (check all that apply)
- ❒ (1) difficulty initiating a stream/bowel movement
- ❒ (2) no perception of bladder fullness
- ❒ (3) weak, slow or intermittent stream of urine
- ❒ (4) frequent toileting to avoid problems
- ❒ (5) dribbling after stream ends
- ❒ (6) pain/burning during urination/defecation
- ❒ (7) blood in stool/urine
- ❒ (8) n/a

1. Occurrence of incontinence or leakage (if this does not apply skip to question #4)
   ❒ (1) times a day _____ ❒ (2) times a week _____
   ❒ (3) times a month_____

2. Severity of Leakage
   - ❒ (1) no leakage
   - ❒ (2) few drops
   - ❒ (3) wet underwear
   - ❒ (4) wet outerwear
   - ❒ (5) other_____

3. Position or activity with leakage
   - ❒ (1) no leakage
   - ❒ (2) lying down
   - ❒ (3) sitting
   - ❒ (4) standing
   - ❒ (5) walking
   - ❒ (6) running
   - ❒ (7) strong urge
   - ❒ (8) coughing
   - ❒ (9) sneezing
   - ❒ (10) laughing
   - ❒ (11) changing positions
   - ❒ (12) sexual act
   - ❒ (13) when constipated
   - ❒ (14) on way to toilet

4. Prolapse (feeling of falling out)
   - ❒ (1) never
   - ❒ (2) occasionally/with menses
   - ❒ (3) pressure at end of day
   - ❒ (4) pressure with straining
   - ❒ (5) pressure with standing
   - ❒ (6) pressure all day

5. How long can you delay the need to eliminate?
   ❒ (A) Bowel ❒ (B) Bladder
   - ❒ (1) indefinitely
   - ❒ (2) 1+ hours
   - ❒ (3) ½ hour
   - ❒ (4) 15 minutes
   - ❒ (5) less than 10 minutes
   - ❒ (6) 1-2 minutes
   - ❒ (7) not at all

6. Ability to stop urine flow
   - ❒ (1) can stop completely
   - ❒ (2) can maintain a deflection of the stream
   - ❒ (3) can partially deflect urine stream
   - ❒ (4) unable to deflect or slow the stream
   - ❒ (5) other _____

7. Fluid Intake _____ 8 oz. glasses per day
   Caffeinated beverages _____ glasses per day

8. Frequency of bowel movements _____ times per week

9. If you are experiencing pain, do your symptoms wake you at night? ❒ (1) No ❒ (2) Yes ❒ (3) N/A
   if "*yes*", is it present
   ❒ (1) while lying still ❒ (2) changing positions ❒ (3) both

10. What aggravates your symptoms? (Check all that apply)
    - ❒ (1) sitting
    - ❒ (2) squatting
    - ❒ (3) standing
    - ❒ (4) sleeping
    - ❒ (5) sexual activity
    - ❒ (6) lying
    - ❒ (7) walking
    - ❒ (8) exercises including _____
    - ❒ (9) repetitive activities including _____
    - ❒ (11) menstruation
    - ❒ (12) sustained bending
    - ❒ (13) taking a deep breath
    - ❒ (14) going to/from sitting
    - ❒ (15) coughing/sneezing
    - ❒ (16) stress
    - ❒ (17) not applicable
    - ❒ (18) other _____

11. What relieves your symptoms? (Check all that apply)

❒ (1) sitting ❒ (6) rest ❒ (10) lying down
❒ (2) heat ❒ (7) standing ❒ (11) massage
❒ (3) cold ❒ (8) walking ❒ (12) medication
❒ (4) stretching ❒ (9) exercise ❒ (13) nothing
❒ (5) rising from sitting ❒ (14) other_____

12. Have you had any previous treatment for this condition? (Check all that apply) ❒ (1) none

❒ (2) laser ❒ (9) pelvic floor exercises
❒ (3) TENS unit ❒ (10) biofeedback
❒ (4) surgery ❒ (11) joint manipulation
❒ (5) dietary changes ❒ (12) ultrasound
❒ (6) physical therapy ❒ (13) injection into the spine
❒ (7) electrical stimulation ❒ (14) overnight hospitalization
❒ (8) injection into the skin/muscles ❒ (15) other _____

Any other concerns not addressed? _____
_____

MEDICATION

In the last 4 weeks have you taken any medication for your current symptoms? ❒ (1) Yes ❒ (2) No
List:_____
_____

Please list any other prescription medications you are currently taking *(pain pills, injections and/or skin patches etc.):*

_____
_____

Are you currently taking any of the following over the counter medications?

❒ (1) aspirin ❒ (5) Vitamins/mineral supplements
❒ (2) Tylenol ❒ (6) Advil/Motrin/Ibuprofen
❒ (3) corticosteroids ❒ (7) other _____
❒ (4) antihistamines

PREVIOUS FUNCTIONAL LEVEL

❒ **Independent in all activities** (work, community, home, recreation)

Self Care

❒ Independent in all self-care (bathing, toileting, dressing, etc.) activities
❒ Have difficulty performing self-care activities
❒ Need assistance with self-care activities
❒ Have difficulty performing household chores

Social

❒ Need assistance with activities in community outside of home

Hobbies:_____
_____

WORK HISTORY

Occupation_____

❒ (1) employed full time ❒ (5) student
❒ (2) employed part time ❒ (6) retired
❒ (3) self employed ❒ (7) unemployed
❒ (4) homemaker ❒ (8) other _____

Physical activities at work

❒ (1) sitting ❒ (5) heavy equipment operation
❒ (2) heavy lifting ❒ (6) driving
❒ (3) repetitive lifting ❒ (7) other_____
❒ (4) computer use

Are you currently receiving for seeking disability for this condition?
❒ Yes ❒ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level? ❒ Yes ❒ No

LIVING SITUATION

❒ live alone ❒ home/apartment
❒ live with caregiver ❒ retirement complex (SNF/ ICF)
❒ live with family member/others ❒ assisted living complex
❒ other _____

Setting

❒ stairs ❒ stairs with railing ❒ ramp ❒ elevator
❒ uneven ground ❒ other _____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Do you exercise outside of normal daily activities?

❒ (1) 5+days/wk ❒ (4) occasionally
❒ (2) 3-4 days/wk ❒ (5) zero
❒ (3) 1-2days/wk

Exercise consisting of_____

Do you smoke?

❒ No ❒ Yes packs of cigarettes a day_____

What is your stress level?

❒ Low ❒ Medium ❒ High

Are you seeing any health care providers other than the physical therapist for this current condition?(list)_____
_____

MEDICAL HISTORY

Have you ever had/ been diagnosed with any of the following conditions?

❒ Cancer (type)_____ ❒ Heart Problems
❒ Depression ❒ High blood pressure
❒ Stroke ❒ Lung Problems
❒ Kidney Problems ❒ Blood Disorders
❒ Thyroid problems ❒ Epilepsy/Seizures
❒ Diabetes ❒ Allergies
❒ Multiple Sclerosis ❒ Rheumatoid arthritis
❒ Arthritis ❒ Osteoporosis
❒ Head Injury ❒ Broken bone
❒ Circulation/vascular problems ❒ Stomach problems
❒ Parkinson's Disease ❒ Other _____
❒ Infectious Diseases (i.e. hepatitis, tuberculosis)

List pelvic/abdominal or bowel/bladder surgeries with dates of operation

SURGERY **DATE**

_____
_____
_____

FAMILY HISTORY

Has anyone in your immediate family *(parents, brothers, sisters)* ever been treated for any of the following?

❒ Diabetes ❒ Cancer
❒ Heart disease ❒ Arthritis
❒ High blood pressure ❒ Osteoporosis
❒ Stroke ❒ Psychological Condition
❒ Other _____