

Lakeview Regional Rehabilitation and Sports Medicine

New Patient History Form for Women's Health

Name: _____ Referred by: _____
Birthdate: _____ Primary Care Physician: _____
Occupation: _____

Please fill in the answers to the best of your ability. Your therapist will review the answers with you during your evaluation.

History of Present Condition

1. Describe your main problem: _____

2. When did your symptoms begin: _____

3. Which of the following **best describes** how your condition started:

- | | |
|---|---|
| <input type="checkbox"/> childbirth | <input type="checkbox"/> a fall |
| <input type="checkbox"/> after surgery | <input type="checkbox"/> lifting |
| <input type="checkbox"/> degenerative process | <input type="checkbox"/> during recreation/sports |
| <input type="checkbox"/> running | <input type="checkbox"/> car accident |
| <input type="checkbox"/> trauma | <input type="checkbox"/> unknown |
| <input type="checkbox"/> other _____ | |

4. Since onset, are your symptoms getting: better worse not changing

5. Which of the following best describes the nature of your symptoms? (check all that apply)

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> constant | <input type="checkbox"/> occasional |
| <input type="checkbox"/> stabbing | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> sharp | <input type="checkbox"/> splitting |
| <input type="checkbox"/> shooting | <input type="checkbox"/> cramping |
| <input type="checkbox"/> dull | <input type="checkbox"/> itching |
| <input type="checkbox"/> tender | <input type="checkbox"/> hot/burning |
| <input type="checkbox"/> aching | <input type="checkbox"/> gnawing |
| <input type="checkbox"/> n/a | <input type="checkbox"/> other _____ |

6. Have you had any previous treatment for this condition? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> physical therapy | <input type="checkbox"/> laser |
| <input type="checkbox"/> pelvic floor exercises | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> dietary changes | <input type="checkbox"/> surgery |
| <input type="checkbox"/> electrical stimulation | <input type="checkbox"/> injection into the skin/muscles |
| <input type="checkbox"/> biofeedback | <input type="checkbox"/> ultrasound |
| <input type="checkbox"/> joint manipulation | <input type="checkbox"/> none |
| <input type="checkbox"/> other _____ | |

7. Describe activities you cannot do because of your problem: _____

8. What are your goals for treatment? _____

Obstetrical/Gynecological History

1. Last pelvic exam (month/year): _____ 2. Last Urinalysis (month/year) _____

3. Other special tests (specify date, type, results): _____

4. Are you sexually active? No Yes

5. Pain or problems with sexual activity? (please describe) _____

6. Have you ever been sexually abused? No Yes

7. Do you have vaginal dryness? No Yes

8. Do you have painful periods? No Yes

9. History of/or present sexually transmitted diseases No Yes, Type: _____
10. Are you currently pregnant or attempting pregnancy? No Yes
11. Number of pregnancies (please include the year): _____
12. Number of Vaginal deliveries: _____ Number of Cesarean deliveries: _____ Weight of largest baby: _____
13. Episiotomies or Tearing? _____ Trouble healing after childbirth? _____
14. Complications from childbirth? _____

Bladder Symptoms

1. Do you have any of the following? (check all that apply)
- difficulty initiating a stream of urine
 - no perception of bladder fullness
 - weak/slow/intermittent stream of urine
 - frequent toileting to avoid problems
 - dribbling after stream ends
 - pain/burning during urination
 - blood in urine
 - pain with full bladder
 - n/a (skip to question #5)
2. Occurrence of incontinence or leakage:
- a. _____ times per day b. _____ times during the night
- c. _____ times per week d. _____ times per month
3. Severity of Leakage: no leakage few drops wets underwear wets outerwear wets floor
4. Position or activity with leakage: (check all that apply)
- no leakage
 - standing
 - jumping
 - sneezing
 - changing positions
 - when constipated
 - lying down
 - walking
 - lifting
 - laughing
 - strong urge
 - other: _____
 - sitting
 - running
 - coughing
 - sexual act
 - on the way to toilet
5. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness / pressure:
- never
 - pressure with straining
 - occasionally/with period
 - pressure with standing
 - pressure at the end of the day
 - pressure all day
6. How long can you delay the need to eliminate?
- indefinitely
 - 15 minutes
 - not at all
 - 1+ hours
 - less than 10 minutes
 - 30 minutes
 - 1-2 minutes
7. Ability to stop urine flow:
- can stop completely
 - can partially deflect urine stream
 - unable to deflect or slow the stream
 - other: _____
8. Do you have:
- trouble emptying bladder completely
 - strain/push to empty bladder
 - dribble after urination
 - constant urine leak
 - trouble feeling bladder urge/fullness
 - recurrent bladder infections
9. Fluid intake: _____ 8 oz glasses per day Caffeinated beverages: _____ glasses per day

Bowel Symptoms (only complete if you are experiencing bowel symptoms)

1. Do you have any of the following? (check all that apply)

- constipation/strain to have a bowel movement
- leak/stain feces
- have diarrhea often
- leak gas by accident
- take laxatives/enema/stool softener regularly
- include fiber in diet
- have pain with bowel movement
- n/a (skip to question #4)

2. Occurrence of bowel leakage:

- a. _____ times per day
- b. _____ times per week
- c. _____ times per month
- d. Only with exertion or strong urge

3. Severity of bowel leakage: stool staining small amount in underwear complete emptying

4. How often do you have a regular bowel movement? _____ per day _____ per week

5. If constipation is present, describe management techniques: _____

6. Most common stool consistency: liquid soft firm pellets other _____

7. How long can you delay the need to eliminate?

- Indefinitely
- 1+ hours
- ½ hour
- 15 minutes
- less than 10 minutes
- 1-2 minutes
- not at all

Pain (only complete if you are experiencing pain)

1. Please rate your pain 0-10 ("0" being no pain, and "10" being excruciating pain): _____

2. Area of pain: back leg groin stomach other _____

3. Is the pain present when you are: lying still changing positions both

4. What aggravates your symptoms? (check all that apply)

- sitting
- squatting
- standing
- going to/from sitting
- sexual activity
- lying
- walking
- menstruation
- sustained bending
- taking a deep breath
- coughing/sneezing
- sleeping
- exercises including _____
- repetitive activities including _____
- other _____

5. What relieves your symptoms? (check all that apply)

- sitting
- heat
- cold
- stretching
- rising from sitting
- rest
- standing
- walking
- exercise
- lying down
- massage
- medication
- nothing
- other _____

6. Does your pain wake you at night? No Yes

Past Medical History

1. How would you rate your general health? excellent good average fair poor

2. How often do you exercise outside of normal daily activities? _____

3. Do you smoke? No Yes

4. Are you taking any medications for your current symptoms?

- No Yes List: _____

5. Please list any other prescription or over the counter medications you are currently taking: _____

6. Have you ever been diagnosed with any of the following conditions? (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Allergies | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Circulation/Vascular Problems | |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Infectious Diseases (Hepatitis, Tuberculosis) | |
| <input type="checkbox"/> Other _____ | | |

7. List any past surgeries with dates of operation

Surgery: _____

Date: _____

Patient Signature: _____ Date/Time: _____

Reviewed By: _____ Date/Time: _____