APEX Physical Therapy & Wellness Center

"Keeping You in Peak Health!"

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WOMEN'S HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient Name: _____ Date:_____

Patient History and Symptoms

Please fill in the following questionnaire to the best of your ability.
What is the primary complaint you are being seen for?_____
_____
When did this problem begin? (Date, approximate if known)_____
Do you currently have the following symptoms?

Y/N Pelvic pain Y/N Blood in urine
Y/N Low back pain Y/N Kidney Infections
Y/N Bladder Infections Y/N Latex sensitivity/allergy
Y/N Internal Foreign Objects (Staples, lap band, IUD, pacemaker, mesh, etc)

If you answered "Yes" to any of the previous questions, please explain:
_____
_____
_____

Health History

Please CIRCLE any of the following health conditions that you now have or had in the past.
None

None	Unexplained weight loss	Tuberculosis	Cancer	Chemical dependency
Kidney disease	Diabetes	Smoker	Anemia	High blood pressure
Seizures	Stroke	Heart problems	Currently pregnant	Osteoporosis/ Osteopenia
Rheumatoid arthritis	History of fractures	Osteoarthritis	Asthma	Menopausal
Thyroid disease	Incontinence	Emphysema	Multiple sclerosis	Depression
Overweight	Hepatitis	Mental illness	Migraines	UTI's
Other:				

Please list any medications that you are taking (over the counter and prescriptions) and list the dosage (Please be specific)

Medication **Dosage**

_____
_____
_____

Please list any surgeries you have had or CIRCLE no surgeries
_____
_____
No surgeries or not related to current information

Obstetrics Health History

Number of Pregnancies:	Number of Vaginal Deliveries:
Birth weight for largest baby:	Number of cesarean deliveries:
Number of episiotomies:	Date of last pap smear:

Did you have any trouble healing after delivery? Yes No _____
Do you have a history of sexual abuse or trauma? Yes No _____
Are you having regular periods/menstrual cycles? Yes No _____
Do you currently or have had issues in the past with fertility? Yes No _____

Urological History

1. How many times do you urinate during the day? _____times per day
2. How often do you wake up to urinate after going to bed? _____times
3. After emptying your bladder do you have the feeling that you have not finished? Yes No
4. Do you experience any leakage of urine? Yes No
5. After you urinate, do you have any dribbling? Yes No
6. Please CIRCLE if you leak urine during the following situations:
   Walking Running Urgency Changing positions (sit→stand)
   Lying Down Exercise Intercourse Straining/lifting Cough/Sneeze/Laugh
7. What amount of leakage do you experience? (CIRCLE)
   Drops More than drops Flood Leak continually
8. Do you use any protection (pad) for urine leakage? Yes No
   If yes, how many per day?_____
9. Do you ever wet the bed while sleeping? Yes No
10. Do you have sensation or awareness when you experience leakage of urine? Yes No
11. Do you find it difficult to begin urinating? Yes No
12. Do you have to strain to pass urine? Yes No
13. Do you have a slow, stop/start or hesitant urinary stream? Yes No
14. Is the volume of urine passed usually: (CIRCLE) Large Average Small Very Small
15. Fluid intake (one glass is 8 oz or one cup)
    ___ of glasses per day (all types of fluid)
    ___ of caffeinated glasses per day
    Typical types of drinks _____

Bowel Symptoms

16. How often do you have a bowel movement?: ___ per day ___ per week.
17. Do you strain to go? Yes No
18. Please CIRCLE the bowel symptoms you are experiencing:
    Diarrhea Constipation Incontinence Laxative Use
    Increased Fiber Use Stool Softener Use Leaking Gas (Flatulence)
19. Do you have pain with bowel movements? Yes No
20. Most common stool consistency? (CIRCLE) Liquid Soft Firm Pellets Other

Sexual Dysfunction

1. Do you experience any pain with intercourse? Yes No

Describe any other sexual pain you may have?_____
_____

On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain (Circle the number)?