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 **CHECK** any of the following health conditions that you now have or had in the past.

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

Other: _____

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

Medication	**Dosage**
_____	_____
_____	_____
_____	_____

Please list any surgeries you have had or ☐ no surgeries

_____

_____

No surgeries or not related to current information

Physical Therapy & Wellness Center

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 **CHECK** 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? (**CHECK**)
   ☐ 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?
14. Is the volume of urine passed usually: (**CHECK**) ☐ 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 **CHECK** 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? (**CHECK**) ☐ Liquid ☐ Soft ☐ Firm ☐ Pellets ☐ Other

Sexual Dysfunctions

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 (CLICK the number)?