ORTHOPEDIC PHYSICAL THERAPY, INC.

Female Pelvic Floor Intake Questionnaire

Date ____________________

Name ______________________________ DOB ____________________

Primary MD ____________________ Referring MD ____________________

Insurance ____________________ Occupation ____________________

Reason for Referral ____

When did problem begin? ____

____

____

RELEVANT HISTORY

Medical History (Fill in background information on the following by checking all that apply to you)

High Blood Pressure _____

Heart Disease _____

Osteoporosis _____

Arthritis _____

Thyroid Condition _____

Respiratory Dysfunctions____

Recurrent muscle or joint pain ________________

Diabetes _____

Breathing Problems _____

Cancer _____

Allergies _____(Please list)

Circulation Disease _____

Medicines Currently Taking: ____

____

____

Surgical History: ____

____

____

____

____

Gynecological History (Please provide information on any of the following that apply to you:)

Have your menstrual periods stopped?: Yes No (circle one)

On hormone replacement therapy? Yes No If yes, which one?_______

Do/did you have pain with your menstrual periods? ____________________

Do/did you have pain with intercourse? Yes No If yes, with initial penetration ____ or deep__

Endometriosis ____ Prolapse _____ Cysts _____ Urinary Tract Infections __________

Pelvic Inflammation Disease ____ Fibroids ____ Pelvic Pain ____

GYN Surgeries: Hysterectomy ________ C-Section __________ Hernia __________

Appendectomy ________ Gall Bladder ____________ Laparoscopy ________

Obstetrical History (for each of your children, provide as much information as possible.)

	Birth Date	Weight	Vaginal/Ceasarean	Prolonged Pushing?	Tearing/Forceps/Episiotomy
1)					
2)					
3)					

Personal History:

Regular Exercise ____

Dietary Habits (meat, fruit, veggies, fiber) ____________________

Caffeine Intake (coffee, tea, soda) ____________________

Fluid Intake/Day (water, juice, milk) ______________________
Sleep Habits (trouble falling asleep, staying asleep, reason for awakening, rested in AM, use of medications to sleep?) ______________________
Sexual Activity ______________________
Social ______________________ Limitations ? ______________________
Work ____________
Life Style Sedentary __________ Active ____________
Travel __________

Special Diagnostic Tests: (please check)

EMG ____
MRI ____
Cystoscope ____
Bladder Stress Test ___
Colonoscopy ____
Pudendal Nerve Test ____
Anal Ultrasound - Momonometry ____
Defecation Proctogram Study ____

Bowels (Loose/Normal/Constipated/Incontinent): ______________________
Form (small/hard, loose, soft/long) ______________________

Bowel Habits (frequency, any laxatives, etc.) ______________________
Do you strain to have a BM? ______________________
BM Frequency times/day ______________ time/wk ______________
Toileting Position ______________________ Splinting Y/N __________%

Bowel Incontinence Symptoms: ____________ N/A
Fecal Leakage _______ episodes per day___week___month ___ other ____________
Leakage Amount ______________________ Pads/day ______________
Gas Control? Y/N ____ Other ______________________

BLADDER QUESTIONNAIRE Please answer these questions to the best of your ability.

	Never	Sometimes	Often
1) Do you leak urine when you cough, sneeze, laugh or when lifting?			
2) Do you ever have such an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?			
3) If "yes" to question #2, do you ever leak before you reach the toilet?			
4) Have you wet the bed in the past year?			
5) Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry?			
6) Do you have an urge to urinate when you hear running water?			
7) Do you have an urge to urinate when your hands are in water?			
8) Do you ever leak during or after sexual intercourse?			
9) Do you find it necessary to wear a pad because of leaking?			
10) If "yes" to questions #9, how many pads a day? ______			
11) Have you had bladder, urinary or kidney infections?			
12) Are you troubled by pain or discomfort when you urinate or BM?			
13) Have you had blood in your urine?			
14) Do you find it hard to begin to urinate?			
15) Do you have a slow urine stream?			
16) Do you strain to pass your urine or BM?			
17) After you urinate, do you have dribbling or a feeling that your bladder is still full?			
18) After BM, do you feel an incomplete emptying?			
19) Do you have burning when you void?			

PLEASE TRY TO GIVE ACTUAL NUMBERS	Number of times
20) How many times during the day do you urinate?	
21) How many times do you void during the night after you go to bed?	
22) How often do you leak?	
23) Leakage equals: Small (less that one-half cup) Large (more than one-half cup)	
24) How much warning time do you have to get to the toilet? Seconds or Minutes	

Pelvic Girdle Pain:

Do you use tampons or pads for menses? ________________________

Are you sensitive to soaps, perfumes, deodorants or laundry detergents? Yes ____ No ____

Rate your pain on the 0-10 scale (10 being worse, ER visit necessary; 0-No pain):

Best _________________ Average _____________ Worst _________________

What activities make the pelvic pain worse? ____

What activities relieve the pelvic symptoms? ____