

FOR INTERNAL USE ONLY  
DOB: \_\_\_\_\_  
Last visit: \_\_\_\_\_  
POC  Yes  No

## PHYSICAL THERAPY WOMEN'S HEALTH SCREENING QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

**Answering the following questions will help us manage your care better. Please complete this form prior to our appointment.**

Please describe your main problem: \_\_\_\_\_

When did your problem begin? \_\_\_\_\_ Is your problem getting:  better  worse  not changing

Do you currently have or have you ever had any of the following? Explain yes responses and include dates.

DATES

DATES

Y N Bladder infections \_\_\_\_\_

Y N Pelvic pain \_\_\_\_\_

Y N Painful intercourse \_\_\_\_\_

Y N Constipation \_\_\_\_\_

Y N Low back pain \_\_\_\_\_

Y N Bone/joint problems \_\_\_\_\_

Y N Abdominal pain \_\_\_\_\_

Y N Sexually transmitted disease \_\_\_\_\_

Y N Menopause \_\_\_\_\_

Y N Other (list) \_\_\_\_\_

Explain yes responses \_\_\_\_\_

	Always	Sometimes	Never
1. Do you have problems with leakage? Urine or stool? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If no, please skip to question 8			
2. Do you lose urine when you have a strong urge to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you lose urine with any of the following?			
Coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Active exercise (running, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Do you lose urine with any of the following? (continued)

	Always	Sometimes	Never
Minimal exercise (walking, light housework, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness or increased anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leakage unrelated to any specific cause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please explain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you empty your bladder before you experience the desire to pass urine just so you can stay dry?  Yes  No

5. With leakage, is your clothing  wet a few drops  wet underwear  wet outer clothes  wet floor?

6. Do you use  sanitary pads  tissue paper  diapers for protection? Name brands \_\_\_\_\_

7. How many protective pads do you use per day? \_\_\_\_\_ Are they  damp  wet  saturated at each change?

8. How often do you urinate each day? \_\_\_\_\_ How often do you urinate at night? \_\_\_\_\_

9. Is the volume of urine you usually pass  large  average  small  very small

10. How many glasses of fluid do you drink per day? \_\_\_\_\_ How many are caffeinated? (coffee, tea, soda) \_\_\_\_\_

11. Do you have any bowel or gas control problems? Please explain: \_\_\_\_\_

12. Do you have a feeling of falling out in the pelvic floor area (prolapse)?  Yes  No

13. Do you have pain with intercourse or urination? Describe: \_\_\_\_\_

14. Are you sexually active?  Yes  No Are you trying to get pregnant?  Yes  No

Number of deliveries: \_\_\_\_\_ Type of deliveries:  Vaginal  Caesarean

Complications: \_\_\_\_\_

15. Have you ever been instructed on pelvic floor or Kegel exercises?  Yes  No

16. Please describe below any vehicle accidents or personal injuries in which you have been involved. \_\_\_\_\_

17. Have you had any operations?  Yes  No If yes, list type of surgeries and dates \_\_\_\_\_

18. Do you currently have or have you ever had any of the diseases listed below?

Y N High blood pressure \_\_\_\_\_

Y N Heart disease \_\_\_\_\_

Y N Diabetes mellitus \_\_\_\_\_

Y N Lung disease \_\_\_\_\_

18 Do you currently have or have you ever had any of the diseases listed below? (continued)

- Y N Stomach disorders (ulcer, etc.) \_\_\_\_\_
- Y N Liver disorders (hepatitis, etc.) \_\_\_\_\_
- Y N HIV positive \_\_\_\_\_
- Y N Glands (thyroid, etc.) \_\_\_\_\_
- Y N Skin disease \_\_\_\_\_
- Y N Cancer \_\_\_\_\_
- Y N Fainting spells \_\_\_\_\_
- Y N Vision problems (not glasses) \_\_\_\_\_
- Y N Hearing problems \_\_\_\_\_
- Y N Multiple sclerosis \_\_\_\_\_
- Y N Stroke \_\_\_\_\_
- Y N Asthma \_\_\_\_\_
- Y N Emphysema/Bronchitis \_\_\_\_\_
- Y N Other \_\_\_\_\_

19. Do you have any allergies?  Yes  No If yes, please list \_\_\_\_\_  
\_\_\_\_\_

20. Do you or any family members have any bleeding tendencies?  Yes  No

21. Are there any diseases or arthritic conditions that run strongly in your family? ?  Yes  No  
If yes, please list \_\_\_\_\_

22. Are you currently taking any medications?  Yes  No If yes, please list \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

24. What are your goals for treatment? \_\_\_\_\_