



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) If no, please skip to question 8 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? _____