Prairie REHABILITATION SERVICES

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			
2. Do you lose urine when you have a strong urge to urinate?	☐	☐	☐
3. Do you lose urine with any of the following?			
Coughing or sneezing	☐	☐	☐
Laughing	☐	☐	☐
Lifting	☐	☐	☐
Active exercise (running, etc.)	☐	☐	☐

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

	Always	Sometimes	Never
Minimal exercise (walking, light housework, etc.)	☐	☐	☐
Sleeping	☐	☐	☐
Changing positions (describe)	☐	☐	☐
Nervousness or increased anxiety	☐	☐	☐
Leakage unrelated to any specific cause	☐	☐	☐
Other, please explain	☐	☐	☐

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? _____