PT CENTER for Women

Medical History and Status Questionnaire

Today's Date: _____ Name: _____ Age: _____ DOB: _____

What are we seeing you for (where is your pain)? _____

When did your pain start (approx)? _____ Has the pain gotten any better, worse, or no change? _____

What does the pain/dysfunction limit you from doing?

	Never Interferes	10-20% of the time	30-40% of the time	50-60% of the time	70-80% of the time	Always Interferes
Household Activities	☐	☐	☐	☐	☐	☐
Physical Activities/Exercise	☐	☐	☐	☐	☐	☐
Work Activities	☐	☐	☐	☐	☐	☐
Intimate Relationships	☐	☐	☐	☐	☐	☐
Walking or Moving	☐	☐	☐	☐	☐	☐
Standing or Sitting through long events	☐	☐	☐	☐	☐	☐
Travel	☐	☐	☐	☐	☐	☐
Sleep (# of times sleep is interrupted)	☐ 0x	☐ 1x	☐ 2x	☐ 3x	☐ 4x	☐ 5+x

Are you taking any medication for this problem (if yes, what kind)? _____

Please rate your pain level from 0-10 (0=no pain, 10=hospitalizing pain): now _____ at best _____ at worst _____

Please check all medical tests/visits that you have had within the past year

☐ Biopsy	☐ Mammogram	☐ Stress test
☐ Blood tests	☐ MRI	☐ Urine test
☐ Bone scan	☐ Myelogram	☐ X-rays
☐ CT scan	☐ Nerve conduction velocity	☐ Urodynamics
☐ EMG (electromyogram)	☐ Stool test	☐ Counselor
☐ Chiropractic care	☐ Pain doctor	☐ Other: _____

Please check all previous procedures/surgeries

☐ Hysterectomy ⇨	Type: ☐ abdominal or ☐ vaginal	☐ ovaries removed		
☐ Hernia repair	☐ C-section			
☐ Appendectomy	☐ Kidney surgery	☐ Back/neck surgery	☐ Colonoscopy	☐ Endoscopy
☐ Gallbladder	☐ Bladder surgery	☐ Laparoscopic	☐ Hydrodystension	

Please check all medical problems that you have now or have had in the past

☐ Low back pain/sciatica	☐ Pelvic/vulvar pain	☐ Rectal pain
☐ Shoulder/wrist/elbow pain	☐ Ankle/foot pain	☐ Pain with intercourse
☐ Knee pain	☐ Carpal tunnel syndrome	☐ Arthritis
☐ Leg cramps	☐ Chronic fatigue syndrome	☐ Light-headedness
☐ Fibromyalgia	☐ Diabetes	☐ Fibroids
☐ High blood pressure	☐ Endometriosis	☐ Kidney disease
☐ Pelvic inflammatory disease	☐ Interstitial cystitis	☐ Migraines
☐ Heart/lung disease	☐ Cancer _____	☐ Head/chest/TMJ
☐ Osteoporosis	☐ Epilepsy	☐ Respiratory problems
☐ Previous strokes	☐ Unusual reaction to hot/cold	☐ STD's
☐ Broken bones	☐ Smoking (_____ packs per day)	☐ Bowel problems
☐ Neck/middle back pain	☐ Hip pain	

Have you ever had physical therapy? ☐ No ☐ Yes Reason? _____

Have you had physical therapy this year? ☐ No ☐ Yes If so, how many visits? _____

Please list your usual recreational and exercise activities: _____

Occupation? _____ ☐ Full Time ☐ Part Time Any Restrictions? _____

☐ Married ☐ Single ☐ Widowed Please list current medications (prescription and non-prescription): _____

_____

Hormone Replacement Therapy (HRT)? ☐ No ☐ Yes ⇨ If yes, ☐ Pill ☐ Patch ☐ Cream ☐ Estrogen ☐ Progesterone

Sexual History

Are you sexually active? ☐ No ☐ Yes Birth Control? _____ Any history of sexual abuse? ☐ No ☐ Yes
Do you have pain with tampon use? ☐ No ☐ Yes Do you have pain with intercourse? ☐ No ☐ Yes

Obstetric History

How many children do you have? _____

If pregnant, what is your due date? _____ Number of weeks gestation? _____

Number of previous pregnancies? _____ Number of C-Sections? _____

Number of episiotomies? _____ Complications of this or other pregnancies? _____

Please check all bladder habits that apply

☐ Frequent urinary tract infections
☐ Strong urge to urinate produces involuntary loss
☐ Loss of urine on the way to bathroom
☐ Urgency when cold/hear running water
☐ Loss of urine upon arriving at bathroom
☐ Pain with urination
☐ Difficulty initiating urine stream
☐ Difficulty stopping urination
☐ Urinary retention
☐ Burning with urination
☐ Loss of urine when coughing, sneezing, lifting, exercising, running, etc.
☐ Blood in urine

Voids/day _____ Voids/night _____ Voids/hour _____

Episodes of involuntary urine loss per day? _____ Amount lost? ☐ few drips ☐ small ☐ continuous dribbling ☐ large

Bed wetting? ☐ No ☐ Yes Do you use a protective pad? ☐ No ☐ Yes Number of pads per day? _____

Do you restrict your fluid intake because of urinary leakage? ☐ No ☐ Yes

How many cups of caffeinated coffee or carbonated beverages per day? _____

Number of cups of water per day? _____ Number of cups of juice per day? _____

Have you ever taken medication(s) to prevent urine loss? ☐ No ☐ Yes

Bowel History

Do you have a gastrointestinal disease? ☐ No ☐ Yes
How do you resolve constipation? ☐ High fiber diet ☐ Laxatives ☐ Enemas
Are you frequently constipated? ☐ No ☐ Yes
Do you frequently have diarrhea? ☐ No ☐ Yes
Do you notice blood in your stool? ☐ No ☐ Yes ⇨ If yes, how often? _____
Do you have hemorrhoids? ☐ No ☐ Yes
Do you have leakage of stool? ☐ No ☐ Yes
Do you have rectal pain? ☐ No ☐ Yes ⇨ If yes, ☐ At rest ☐ Sharp, fleeting pain ☐ Only with bowel movement

Please rate how your pain/dysfunction interferes with your quality of life:

Doesn't interfere 0 1 2 3 4 5 6 7 8 9 10 Disabling pain/dysfunction