Women's Medical History Questionnaire

Welcome to Central Bucks Physical Therapy

Please take the time to complete this questionaire in as much detail as possible. We understand that some of the questions are very personal and this information is valuable to your Physical Therapist.

NAME: ______________________________ DATE: __________

Date of Birth: ___/___/___ Age: _____ Weight: _______ Height: _______

Gender Indentity: _________ Relationship Status: ________

Refering Physician:

Primary Care Physician:

What brings you here today?

____

____

____

____

When/How did your condition begin?

____

____

____

____

What do you hope to achieve by attending physical therapy?

Be as specific as possible: ie: Sit 45 minutes with no pain

____

____

____

____

Circle which activity or activities you have found to help your symptoms feel BETTER?							
Meditation	Relaxation	Lying Down	Music	Massage	Ice	Medication	Heating Pad
Laxatives	Bowel Movement	Sitting	Standing	Empyting Bladder	Weather	Orgasm	
Exercise	Walking	Time of Day	Nothing	Other:			

Circle which activity or activities you have found to help your symptoms feel WORSE?							
Worry	Lifting	Stress	Full Meal	Intercourse	Full Bladder	Urination	
Bowel Movement	Sitting	Standing	Empyting Bladder	Weather	Orgasm	Fear	
Exercise	Walking	Time of Day	Coughing/Sneezing	Other:			

Allergies/Sensitivities:			
Medicine:	NO	YES	if yes: List Medications:
Food Allergy:	NO	YES	if yes, which: Gluten Peanut Dairy Other:
Food Sensitivities:	NO	YES	if yes, specify:
Latex Allergy/Sensitivity:	NO	YES	if yes which? Allergy or Sensitivity
Other Allergies:	NO	YES	if yes, specify:

NAME:	DATE:

Listing of your other health care providers:

	Physician Name	Date of Last Visit
Obstetrician/Gynecologist:		
Gastro-enterologist/Colo-Rectal:		
Urologist:		
Urogynecologist:		
Sexual Health Specialist:		
Pyschologist/Psychiatrist:		
Oncologist:		
Chiropractor:		
Nutritionist:		
Other:		

PERSONAL MEDICAL HISTORY: Circle your answer and describe if indicated.

Cancer:	NO YES, if yes, describe:
Thyroid Condition:	NO YES, If yes: Hypothyroid Hyperthyroid Other
Diabetes:	NO YES, if yes, describe:
Asthma:	NO YES
Heart Conditions:	NO YES, if yes, describe:
Seizures:	NO YES, if yes, describe:
Blood Pressure Conditions:	NO YES, if yes, High or Low Blood Pressure
Has a physician ever told you that you have an abdominal aortic aneurysm?	NO YES
Circulation Condition:	NO YES
Blood Clots:	NO YES
Stroke:	NO YES
Anxiety:	NO YES
Depression:	NO YES
Arthritis:	NO YES, if yes, describe:
Osteoporosis or Osteopenia:	NO YES, if yes which?
Fibromyalgia:	NO YES
Neuropathy:	NO YES, if yes, describe:
Migraines:	NO YES
Autoimmune Conditions:	NO YES, if yes, describe:
Kidney Conditions:	NO YES, if yes, describe:
Substance Dependency:	NO YES, if yes: Alcohol, Marijuana, Drugs, Other:
Genetic Disorders:	NO YES
Have you taken steroid medications for any medical conditions?	NO YES
Have you taken blood thinning medications for any medical conditions?	NO YES
Have you taken anti-biotics in the past 3 months?	NO YES

SURGICAL HISTORY:

DATE OF SURGERY	TYPE OF SURGERY	AGE AT THE TIME OF SURGERY

HOSPITALIZATIONS: other than for surgery listed above

NAME:	DATE:

MEDICAL TREATMENT of FRACTURES, SPRAINS, DISLOCATIONS OR JOINT INSTABILITIES?

MEDICATIONS: List all of your medication prescribed to you by your physician: Attach a additional sheet if needed.

Medication	Dosage	Frequency	Oral/Injectables/Suppository/Inhaled/Transdermal

OVER THE COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS/HERBAL REMEDIES

Over The Counter: (Antacids/Tylenol/Aspirin, etc)

Medication	Dosage	Frequency

VITAMINS/SUPPLEMENTS/HERBAL REMEDIES

Supplement	Frequency

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

If you answered yes to either of the last 2 questions, is this something with which you would like help?

Circle Answer: YES YES, but not today NO

OB/GYN History:

Do you experience pain with gynecologist speculum exam? NO YES

Do you experience pain using a tampon? NO YES I choose not to use tampons

IF you are menstruating has your flow changed in anyway listed here? N/A

Length Missed Periods Abnormal Bleeding

Do you have a period every month? NO YES, if yes, please answer the following questions:

* Number of days of flow? _____ * If you experience cramps are they? Mild Moderate Severe

* Do you experience mid cycle pain? NO YES

Have you reached menopause? NO YES, if yes when?

Are you experiencing night sweats, hot flashes, vaginal dryness or insomnia? NO YES

IF you have diagnosed with any of the following conditions, please circle:

Vulvodynia Vulvar Vestibulitis Lichen Sclerosis Endometriosus Polycystic Ovary Syndrome (PCOS)

Do you feel pressure in your vagina? NO YES, if yes, when does it worsen?

Are you trying to get pregnant? NO YES, if yes for how long?

If applicable: How many pregnancies have you had - note the number below:

Full 9 months: Premature: Miscarriage/Abortion: # of Living Children:

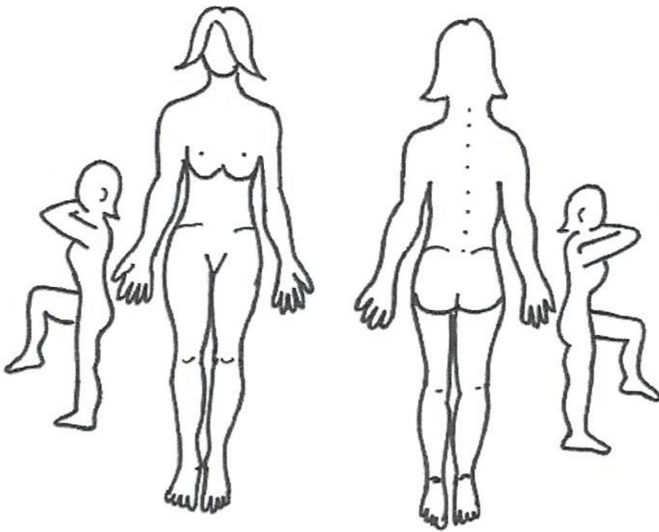
Type(s) of delivery: Vaginal Cesarean

Interventions: Epidural Induction Forceps Vacuum Episiotomy

Have you noticed a bulge in your abdomen since delivery? NO YES

NAME: ______________________________ DATE: __________

Draw the location of your symptoms on the diagram and describe on the side:



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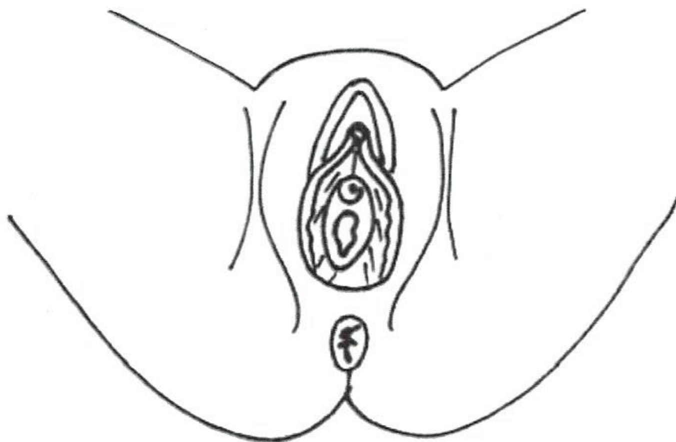
Pelvic Floor Region: Draw the location of your symptoms on the diagram and describe on the side:



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Staff Use: Visual Analog Score: Current	At Rest	Average 2 wks

NAME: DATE:

BOWEL FUNCTIONS:

How often do you move your bowels? Daily Every Other Day Every 2 days Every 3 days Other

Has your bowel schedule changed recently? If yes, how?

Do you have Constipation or Diarrhea? NO YES, if yes, which and for how long?

What do you do for your constipation or diarrhea?

Do you have trouble feeling bowel urge? NO YES

Do you have trouble holding back gas? NO YES

Have you had blood in your stools? NO YES

Have you had dark colored stools? NO YES

Are you stools narrow like a pencil? NO YES If yes, for how long?

Do you have or had hemorrhoids? NO YES

Have you had or are you experiencing an anal fissure? NO YES

Have you had or are you experiencing leakage of feces? NO YES if yes, partial/smear/full loss

Does your rectum slide out of the canal? NO YES

URINARY FUNCTIONS:

Do you have difficulty starting urine flow? NO YES

How is your urine flow? Circle all that apply: SLOW, FULL, FAST, SPORADIC, HESISTANT

Do you have a shy bladder? NO YES

Do you have trouble emptying your bladder? NO YES

Do you experience painful urination? NO YES

Have you had blood in your urine? NO YES

How often to you urinate during the day? 3-6 7-10 11-14 15-19 20 or more

If you get up to urinate during the night, how many tines? 0 1 2 3 4 5 or more

Has the color of your urine changed? NO YES if yes, is it brown or tea colored? NO YES

Do you have difficulty stopping urine flow? NO YES

Do you experience a strong urge to urinate? NO YES

Do you have urinary leakage? NO YES if yes, answer the questions below:

When? Daytime Night-time Constant With sneeze/laugh/exercise On the way to the bathroom

How much leakage? Just a few drops Wets underwear Wets outwear Wets floor

Do you wear a pad? NO YES if yes, what type of pad? How many used in 1 day?

SEXUAL HISTORY/FUNCTION: Only answer if you feel comfortable.

Are you sexually active? NO YES

Are you experiencing sexual difficulties? NO YES

Who is your sexual partner(s)? Spouse Partner Men Women Both

Do you or your partner use contraception? NO YES if yes, type?

If you masturbate do you experience pain? NO YES

Are you comfortable engaging in intercourse? NO YES

Have you ever had a sexually transmitted disease? NO YES if yes, which?

Do you experience pain with deep thrusting during intercourse? NO YES

Do you experience pain with orgasm? NO YES

If you experience pain with intercourse, does it make you avoid it? Never Occasionally Usually Always

NAME:	DATE:

In the past 3 months have you had any of the following? If yes, please describe.

Skin Rash:	NO YES	
Fatigue:	NO YES	
Weakness:	NO YES	
Tremors:	NO YES	
Hair Loss:	NO YES	
Difficulty Swallowing:	NO YES	
Hoarse Voice:	NO YES	
Chest Pain:	NO YES	
Warm Palms:	NO YES	
Feeling " Not Right":	NO YES	
Falls:	NO YES	
Hearing Problems:	NO YES	
Numbness/Tingling:	NO YES	
Joint/Muscle Swelling:	NO YES	
Easy Bruising:	NO YES	
Mood Changes:	NO YES	
Dry Mouth:	NO YES	
Mouth Sores:	NO YES	
Out of breath at rest:	NO YES	
Out of breath at activity:	NO YES	
Heart Racing:	NO YES	
Abdominal Pain:	NO YES	
Unexplained Weight loss/gain?	NO YES	
Vision Questions:		
Double Vision:	NO YES	
Loss Of Vision:	NO YES	
Eye Redness/Dryness:	NO YES	
Wear Glasses:	NO YES	
Cataracts:	NO YES	
Macular Degeneration:	NO YES	

Over the past 2 weeks, how often have you been bothered by the following problems? Circle your answer

Feeling nervous, anxious or on edge	Not at all	Several Days	Over Half the Days	Nearly Every Day
Not being able to stop or control worrying	Not at all	Several Days	Over Half the Days	Nearly Every Day
Worrying to much about different things	Not at all	Several Days	Over Half the Days	Nearly Every Day
Trouble Relaxing	Not at all	Several Days	Over Half the Days	Nearly Every Day
Being so restles that it's hard to sit still	Not at all	Several Days	Over Half the Days	Nearly Every Day
Becoming easily annoyed or irritable	Not at all	Several Days	Over Half the Days	Nearly Every Day
Feeling afraid as if something awful might happen	Not at all	Several Days	Over Half the Days	Nearly Every Day

HEALTH AND LIFESTYLE

Are you presently working? YES NO if no, are you Retired? On Disability? Or Other?

What is/was your Occupation?

Describe your work: Full-time Part-time Occasional Other:

Physically Demanding Sedentary Travel Data Entry Other

NAME:	DATE:

HEALTH AND LIFESTYLE CONTINUED

Do you have someone to help you at home? NO YES, if yes, who?

Do you have a support system that you can rely on? NO YES, if yes who? Partner Family Friends

Are you concerned about someone else's health or lifestyle? NO YES

Have you ever suffered a traumatic event? (Physical, Emotional or Other)? NO YES

Have your received psychotherapy? NO YES, if yes, are you currently in psychotherapy? YES NO

Have you ever been a victim of sexual abuse? NO YES

Have you ever been a victim of emotional abuse (including humiliation or insult)? NO YES

Do you feel unsafe where you live or has anyone tried to hit or tried to hurt you in any way? NO YES

Do you have an exercise regime? NO YES if yes, type and frequency:

Do you participate in leisure activities? NO YES if yes, describe:

Are your symptoms limiting your ability to participate in leisure activities? NO YES

Do you need help with daily activities? NO YES, if yes circle the daily activities:

Bathing Dressing Shopping Driving Cooking Laundry Housekeeping Finances Other:

How would you rate your overall health? POOR FAIR GOOD EXCELLENT

How is your appetite? POOR FAIR GOOD EXCELLENT

How would you rate the nutritional content of your diet? POOR FAIR GOOD EXCELLENT

Do you follow a special diet? NO YES, if yes, describe:

LIVING SPACE

Please circle the most appropriate option to describe your home:

One Story 2 or more stories Steps to enter: how many? Railing

I have provided my health information to the best of my knowledge and agree to be evaluated by a Physical Therapist. I understand if I am uncomfortable that I can refuse any portions of the evaluation. I also understand that treatment options will be discussed and I can refuse any treatments offered.

Signature: ____________________ **Date:** _____/_____/_____

If someone helped you complete this form, please have them sign and print their name here.

Person helping with the completion of this form: ____________________

Print Name: ____________________ Relation: ____________________

Thank you for taking the time to complete this important information.

I have reviewed and discussed the above information with the patient.

Physical Therapist Signature: ____________________ Date: _____/_____/_____