DESERT PHYSICAL THERAPY
WOMEN'S HEALTH QUESTIONNAIRE Date:_____

Name:_____ Date of Birth:_____ Age:_____

Please describe your main problem:_____
_____

When/How did it occur?_____
_____

Do you feel your problem is **getting better**, **worse**, or **staying the same**? (Circle one)

What activities are you unable to do or limited in?_____
_____

Date of last physician's appointment:_____ Date of next physician's appointment:_____

Current medications:_____
_____

Have you had any special tests to evaluate your current problem? **___Yes ___No**
If Yes, please describe:

Have you had any pelvic/abdominal surgeries? **___Yes ___No**
Please list surgeries and when each occurred:

Do you have a history of bladder or yeast infections? **___Yes ___No**
How many per year?_____

Have you gone through menopause? **___Yes ___No**
If Yes, when?_____

Have you ever been pregnant? **___Yes ___No**
Vaginal deliveries:_____ # C-sections:_____
Did you have any complications during childbirth?_____
Are you currently pregnant or attempting to get pregnant?_____
If you are pregnant, when is your due date?_____

Plese make an "X" to indicate if you have had any of the following:

__ AIDS/HIV	__ Fractures	__ Osteoporosis	**HABITS:**
__ Anemia	__ Head Injury	__ Pacemaker	__ Smoking
__ Appendicitis	__ Heart Condition	__ Parkinson's	Packs/day:
__ Arthritis	__ Hepatitis	__ Pinched Nerve	__ Alcohol
__ Asthma	__ Hernia	__ Pneumonia	Drinks/week:
__ Bleeding Disorder	__ Herniated Disk	__ Polio	__ Caffeinated Drinks
__ Breast Lump	__ High Blood Pressure	__ Physical/Sexual Abuse	Drinks/day:
__ Bronchitis	__ High Cholesterol	__ Prosthesis	
__ Cancer	__ Kidney Disease	__ Rheumatoid Arthritis	**Please list any other**
__ Chemical Dependency	__ Liver Disease	__ Skin Disorder	**relevant medical history:**
__ Concussion	__ Lung Condition	__ Steroid Use	
__ Depression	__ Migraines	__ Stroke	
__ Diabetes	__ Multiple Sclerosis	__ Tuberculosis	
__ Epilepsy	__ Muscle/Tendon Injury	__ Tumors/Growths	
__ Fibromyalgia	__ Nervousness/Anxiety	__ Ulcers	

Are you currently working? ____Yes ____No **Full Time, Part Time, Light Duty** (Circle One)

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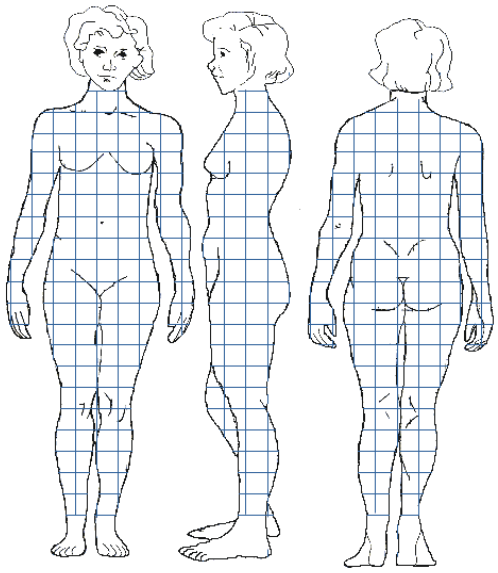
Pain History:

Please make an "X" on the diagram over any areas of pain:



Please indicate your average level of pain below:

0	10
No Pain	ER Visit

Please circle any symptoms you are having listed below:

Back pain - Muscle/Joint pain - Headache - Pain before/during period

Pain/burning with intercourse - Pain lasting hours/days after intercourse

Pain in groin when lifting - Pain when bladder is full - Pain with urination

Please indicate your level of stress below:

0	10
No Stress	Extreme Stress

Bladder History:

How many times per day do you urinate?_____

Do you ever get up to urinate at night? **___Yes ___No**

Do you leak urine? **___Yes ___No**

If Yes, please answer the following questions:

How often? _____

Is it necessary to wear a pad because of urine leakage? ___Yes ___No

Please circle which type of pad is warn most often:

Pantishield, Mini Pad, Maxi Pad, Serneity, Diaper

In general, how severe is your urine leakage? (Circle one)

Few drops, Wet underwear, Wet outer wear

What position are you in when you have leakage? (Circle all that apply)

Lying down, Sitting, Standing, Changing position (ex: from sitting to standing)

Do you experience a loss of urine with: (Circle all that apply)

Coughing, Laughing, Sneezing, Lifting objects, Exercise, Jumping

Do you ever have to rush to the toilet because of a strong urge to urinate? ___Yes ___No

If Yes, do you ever leak before reaching the toilet? ___Yes ___No

Is it ever difficult to begin urinating? ___Yes ___No

Do you have to strain to empty your bladder? ___Yes ___No

After starting to urinate, do you feel that you could stop the urine flow? ___Yes ___No

Do you have regular bowel movements? **___Yes ___No**

How often? (Circle one) More than once/day, Once/day, 3x/week, Weekly, Other:_____

Are you sexually active? **___Yes ___No**

Have you ever been taught to do pelvic floor or Kegel exercises? **___Yes ___No**

What are your personal goals with Physical Therapy?_____

_____

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