

Women's Health Screening Questionnaire

To ensure a thorough evaluation, please provide this important information about your medical history.

Name _____ **DOB** _____ **Age** _____ **Height** _____ **Weight** _____

How would you **rate** your general health? (*circle one*) Poor / Fair / Good / Excellent

What brings you to PT today? (brief description of symptoms) _____

Onset Date _____ **Sudden / Gradual** (*circle*) Are your symptoms: **New / Recurring** (*circle*)

Have you had treatment/ diagnostic tests for this? **Y N** If yes, what? _____

What is your GOAL with Physical Therapy? _____

Birth History Number of pregnancies: _____ Number of live births: _____ Number of difficult births: _____

Date	2 nd Stage/Pushing duration	C-Section/Vaginal	Baby weight	Episiotomy/ tear grade
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1. _____

2. _____

3. _____

4. _____

Did you have trouble healing after a delivery?	Y	N
Do you have a history of sexual abuse or trauma?	Y	N
Are you having regular menstrual cycles?	Y	N
Do you have an IUD in place?	Y	N
Do you have frequent urinary tract infections?	Y	N
Have you had endometriosis, fibroids, or cysts?	Y	N
Do you have any product allergies? (ie latex)	Y	N

If yes, please list: _____

HAVE YOU EVER BEEN DIAGNOSED WITH:

Diabetes	Y	N	Stroke	Y	N
Fibromyalgia	Y	N	Scoliosis	Y	N
Osteoarthritis	Y	N			
Osteoporosis/ osteopenia	Y	N			
Cancer				Y	N
Type _____		Date _____			
Heart Problems				Y	N
Type _____		Date _____			
Lung Problems				Y	N
Type _____		Date _____			
Infectious Disease				Y	N
Type _____		Date _____			
Other: _____					

Test Results

Urodynamic	Y	N	date/ results: _____
Cystoscope	Y	N	date/ results: _____
Urine tests	Y	N	date/ results: _____
Bowel tests	Y	N	date/ results: _____
X-Ray, MRI, CT	Y	N	date/ results: _____

Have you experienced these in the **PAST 2 WKS?** (*circle*)

Chills or Fever	Bowel/ bladder changes
Fatigue	Dizziness
Headaches	Nausea/ Vomiting
Night sweats	Numbness/ Tingling
Sleep disturbance	Swelling
Unexplained weight loss/ gain	Weakness

Which **Over-the-Counter** and **Prescription** medications have you taken in the past **3-4 weeks?** Please list:

OTC: _____

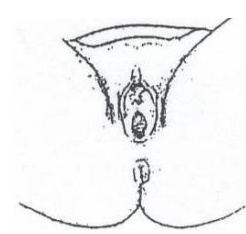
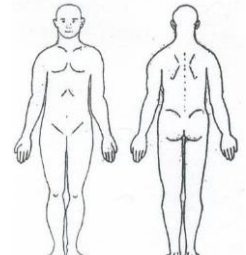
Prescription: _____

INDICATE and RATE YOUR PAIN with each activity:

(☺ 0 1 2 3 4 5 6 7 8 9 10 ☹)

Sexual intercourse	Y	N	____/10
Pelvic Exam	Y	N	____/10
Tampon Use	Y	N	____/10
Other _____			____/10
Do you have abdominal pain?	Y	N	____/10
Do you have back, leg, or groin pain?	Y	N	____/10

Please INDICATE on the diagram your AREA(S) of pain:

List **ANY** previous **SURGERIES/ INJURIES/ MEDICAL CONDITIONS** (even if not directly related)

DATE	SURGERIES/ INJURIES/ MEDICAL CONDITIONS	REASON

What makes your symptoms BETTER? (please circle)

Heat	Sitting	Nighttime	Exercise	Walking	Hot bath	Urination	Position changes
Ice	Standing	Medication	Stretching	Resting	Nothing changes my symptoms		
Enema	Massage	Relaxation	Laxatives	BM	Other: _____		

BLADDER SYMPTOMS, Do you:

Wet the bed?	Y	N
Have burning/ pain with urination?	Y	N
Strain to empty your bladder?	Y	N
Have a frequent, strong urge to urinate?	Y	N

~Number of times you urinate per day: _____

When you leak, how much do you leak? (circle)

Droplets	Need to change underwear
Need to change pad	

Do you have a "falling out" feeling?	Y	N
Feel unable to empty bladder?	Y	N
Have difficulty starting stream of urine?	Y	N
Have pain with a full bladder?	Y	N

~Number of times you urinate at night: _____

Do you lose urine when you:

Cough/ sneeze/ laugh?	Y	N
Have intercourse?	Y	N
Walk to the bathroom?	Y	N
Enter your home/ key in door?	Y	N
Feel nervous or anxious?	Y	N
Lift/ exercise/ dance/ jump?	Y	N
Running?	Y	N

Other: _____

BOWEL SYMPTOMS, Do you:








Leak/ stain feces?	Y	N
Leak gas by accident?	Y	N
Strain to have a bowel movement?	Y	N
Have pain with bowel movements?	Y	N
Have frequent, strong urges to move bowels?	Y	N
Take laxatives/ enema regularly?	Y	N

How often do you move your bowels?

_____ times per day OR week (please circle)

Please circle your most common stool consistency on the Bristol Stool Chart:

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

What form of protection do you wear? (circle):

None

Minimal (tissue paper/panty liner)

Moderate (absorbent product/ maxi pad)

Maximum (specialty product/ diaper)

Signature: _____
 Date: _____