thrive INTEGRATED PHYSICAL THERAPY

PELVIC PT INFORMATION SHEET

Name: _____

HISTORY

What is your chief complaint: _____

Number of pregnancies: _____ Number of vaginal deliveries: _____

Birth weight of largest baby: _____ Number of cesarean deliveries: _____

Number of episiotomies: _____ Date of last pap smear: _____

Did you have any trouble healing after delivery: Y / N

Do you have a history of sexual abuse or trauma: Y / N

Are you having regular periods/ menstrual cycles: Y / N

Do you have frequent urinary tract infections: Y / N

TEST RESULTS

Urodynamics Test: Y / N Results: _____

Cystoscope: Y / N Results: _____

Urine Test: Y / N Results: _____

Bowel Test: Y / N Results: _____

PAIN

Do you have back, leg, groin or abdominal pain: Y / N

Do you have pain with:

- Sexual intercourse Y / N
- Pelvic exams Y / N
- Tampon use Y / N

BLADDER SYMPTOMS

Do you lose urine when you:

- Are on the way to the bathroom Y / N
- Have a strong urge to urinate Y / N
- Hear water Y / N
- Cough / sneeze / laugh (circle all that apply)
- Lift / exercise / dance / jump (circle all that apply)
- Other _____

Do you:

Wet the bed Y / N

Have burning /pain with urination Y / N

Have difficulty starting a stream of urine Y / N

Strain to empty your bladder Y / N

Feel unable to empty bladder fully Y / N

Have a falling out feeling Y / N

Have pain with a full bladder Y / N

Have an urgency of urination (a strong urge to urinate) Y / N

Urinate more than 7 times per day Y / N

BOWEL SYMPTOMS

Do you:

Strain to have a bowel movement Y / N

Leak / stain feces Y / N

Include fiber in your diet Y / N

Have diarrhea often Y / N

Take laxatives / enema regularly Y / N

Leak gas by accident Y / N

Have pain with bowel movement Y / N

Have a very strong urge to move your bowels Y / N

How often do you move your bowels: _____ per day, week

Most common stool consistency (circle): liquid / soft / firm / pellets / other _____

Thank you for taking the time to fill out this questionnaire.

Patient Signature _____ Date _____