PELVIC HEALTH MEDICAL HISTORY (Female)

Please answer only the questions that apply to you. Your answers will help us to perform a thorough evaluation and then develop a more effective treatment plan for your condition.

Please describe your pain/ problems: _____

Please Rate your level of pain on this scale 0-10 (0 = no pain, 10 = severe pain) Please click here to select one:

What do you think is causing your pain/problem? _____

Is there an event that you associate with the onset of your pain/problem? Please click here to select one:
If so, what? _____

How long have you had this pain/problem? _____

Is your problem affecting your quality of life in the following ways?: (please check all that apply)
____ Travel ____ Social ____ Sleep ____ Job ____Self-Care (dressing, bathing)
____ Household/Yard Work ____ Exercise

SYMPTOMS:
Do you have pain with any of the following? (Please check all that apply.)
____ Pain with Urination ____ Pain with bowel movements ____ Pain with gynecological exams
____ Pain when bladder is full ____ Pain with tampon insertion ____ Pain during/after intercourse

BLADDER:
Do you experience any of the following?

- Loss of urine when coughing, sneezing, or laughing? Please click here to select one:
- Loss of urine with a strong urge to urinate? Please click here to select one:
- Very strong urgency to urinate with little warning? Please click here to select one:
- Frequent bladder infections? Please click here to select one:
- Do you feel like you completely empty your bladder? Please click here to select one:

How many times do you urinate during the day? _____ How often? _____ (minutes, hours, etc.)

How often do you leak urine? Please click here to select from the list	How much urine do you leak? Please click here to select from the list
What type of pads do you use? Please click here to select from the list	How many pads do you use? Please click here to select from the list
How often do you get up at night to urinate? Please click here to select from the list	Activity that causes urine loss Please click here to select from the list

BOWEL:
On average how many bowel movements do you have? Daily: _____Weekly: _____

Do you experience any of the following? (Please circle your answer.)

- Strong urge and have to rush to the bathroom for a bowel movement Please click here to select YES or NO
- Sensation of incomplete emptying after a bowel movement? Please click here to select YES or NO
- Sensation of abdominal fullness, bloating, swelling? Please click here to select YES or NO
- Fecal incontinence (involuntary loss of stool)? Please click here to select YES or NO

Quality of your stool: (Please check all that apply.)

____ Hard (Lumpy or Pellets) ____ Loose, soft pieces ____ Soft, solid
____ Watery ____ Mucous ____ Small thin, long

PREGNANCY HISTORY:
How many pregnancies have you had? _____ How many live births? _____

Did you have any complications during pregnancy, labor, or postpartum period? (Please check all that apply.)

____ Episiotomy ____ Forceps ____Back, pelvic, or hip pain
____ Vaginal lacerations (tear) ____ C-section ____ Postpartum hemorrhage or medication for bleeding

MENSTRUAL HISTORY:
When was your last menstrual cycle? _____

Is your menstrual cycle regular? If not, how often do you have a menstrual cycle? _____

Are you currently on birth control? If so, what type? _____

When wawa your last gynecological / physical exam? _____

ABUSE HISTORY:
Have you ever been the victim of emotional, physical, or sexual abuse? Please click here to select YES or NO

MEDICATIONS:
Are you currently taking any medications? Please click here to select YES or NO
If **YES** provide us with a copy of your medication or write on the bottom of this page.

SURGICAL HISTORY: Provide us with a copy of your surgical history or fill in below. Skip if completed online.

SURGERY	DATE(S)

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the physical therapy evaluation for the problems you have reported, an assessment of your low back, hips, and pelvic girdle will be performed by a physical therapist in order to identify any musculoskeletal problems. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). The findings will be discussed with you, and you will work with your physical therapist to develop a treatment plan that is appropriate for YOU. Your evaluation MAY include an internal assessment of the pelvic floor muscles, which could be completed vaginally (females) or rectals (males & females). A biofeedback assessment of your pelvic muscles may also be performed and may include internal or external sensors. Your physical therapist will discuss this option and receive your consent BEFORE initiating this exam. You absolutely can say NO, and your physical therapist can assess and treat the pelvic floor externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

We realize that many patients may be apprehensive because of the private nature of this condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinical staff member. Please indicate your preference with your initials.

_____ **YES** I want a second person present during the pelvic floor muscle evaluation and treatment.

_____ **NO** I do not want a second person during the pelvic floor muscle evaluation and treatment.

_____ I would like to discuss my options with my physical therapist prior to consenting.

CONSENT

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, an dI consent to the evaluation and treatment, unless otherwise noted below.

(Please list any exception to consent above - If none, write “none”)

Signature: _____ Date: _____