pelvic health
and performance center
LEARN • HEAL • THRIVE

Patient History

Name: _____ Age: _____ Date of Birth: _____

What are your pronouns?

☐ He/him/his ☐ She/her/hers ☐ They/them/theirs

☐ Ze/hir/hirs ☐ : _____

What is your gender identity?

☐ Male ☐ Gender nonconforming ☐ Transgender woman/Transwoman

☐ Female ☐ Transgender man/Transman ☐ Non-binary

What sex were you assigned at birth? ☐ Male ☐ Female ☐ Decline to state

Describe the current problem that brought you here:

_____

_____

When did your problem first begin? ☐ months ago, ☐ years ago, ☐ Other: _____

Was your first episode of the problem related to a specific incident or accident? Y/N
Please describe and specify date:

_____

_____

Since that time, is it: ☐ staying the same, ☐ getting worse, ☐ getting better?

Why or how is it getting better?

_____

If pain is present, rate it from 0-10, with 0 being no pain and 10 being the worst: _____
Describe the nature of the pain (e.g., constant burning, intermittent ache) and its location:

_____

_____

Describe any previous treatment/exercises: _____

_____

What are your treatment goals/concerns? _____

_____

Medications (pill, patch, injection):	Reason for Taking

Activities/events that cause or aggravate your symptoms. Check all that apply.

☐ Sitting greater than _____minutes
☐ Walking greater than _____ minutes
☐ Standing greater than _____ minutes
☐ Changing positions (e.g., sit to stand)
☐ Light activity (light housework)
☐ Vigorous activity/exercise (run/weight lift/jump)
☐ With triggers (e.g., running water)
☐ Other, please list: _____
☐ With cough/sneeze/straining
☐ With laughing/yelling
☐ With lifting/bending
☐ With cold weather
☐ Sexual activity
☐ With nervousness/anxiety
☐ No activity affects the problem
☐ Other, please list:_____

What relieves your symptoms?

_____
_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other/describe: _____		

How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify: _____

Diet /Fluid intake, specify: _____

Physical activity, specify: _____

Work, specify: _____

Sexual activity, specify: _____

Other: _____

Rate the severity of this issue from 0-10, with 0 being no problem and 10 being the worst:

_____

General Health History

Date of Last Physical Exam: _____ Tests performed: _____

_____

Overall Health:

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Occupation: _____ Hours/week_____ On disability or leave? _____

Activity Restrictions? _____

How many hours do you sleep a night on average? _____

What activity/exercise do you enjoy doing?

_____

How frequently do you exercise?

☐ Not at all ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week

How would you describe your current eating habits?

☐ Vegetarian ☐ Vegan (plant based) ☐ Nut-free
☐ Pescatarian (fish) ☐ Omnivore (meat and plant based) ☐ FODMAP
☐ Gluten-free ☐ Dairy-free ☐ Grain-free
☐ Other/Describe _____

Current level of stress: ☐ High ☐ Medium ☐ Low
Please describe the strategies you use to manage your stress:

_____
_____

Do you feel that you manage your stress well? ☐ Yes ☐ Sometimes ☐ No
Y/N Are you currently in counseling/ therapy? Y/N Are you interested in counseling/therapy?

Have you ever had the following conditions or diagnoses? Circle all that apply /describe.

Cancer	Stroke	Emphysema/Chronic Bronchitis
Heart Problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies (list below)
Ankle Swelling	Head Injury	Latex Sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low Back Pain	Chronic Fatigue	Headaches
Sacroiliac/Tailbone Pain	Fibromyalgia	Diabetes
Alcoholism/Drug Abuse	Arthritic Conditions	Kidney Disease
Childhood Bladder Issues	Stress Fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis
Postpartum Depression (PPD)	Ehlers Danlos Syndrome	HIV/AIDS
Anorexia/Bulimia	Joint Replacement	Sexually Transmitted Disease
Smoking History	Bone Fracture	Physical or Sexual Abuse
Vision/Eye Problems	Sports Injuries	Raynaud's
TMJ/ neck pain	Pelvic Pain	Hearing Loss
Hemorrhoids	Varicose Veins	Food Sensitivities (list below)

Other/Describe:_____

Surgical /Procedure History

Y/N	Back/Spine	Y/N	Bladder
Y/N	Joint replacement	Y/N	Gender specific organs
Y/N	Prostate	Y/N	Bone Fracture
Y/N	Brain Injury	Y/N	Abdominal Organs

Other/Describe: _____

Obstetric/Gynecological History

Current Status (please read carefully, and skip the sections that do NOT apply to you):

___ **I AM NOT PREGNANT/THIS DOES NOT APPLY TO ME**

___ **I RECENTLY EXPERIENCED THE LOSS OF A PREGNANCY.**

If you have recently experienced the loss of a pregnancy, is there any additional information that you feel comfortable sharing?

_____

_____

___ **I HAVE GIVEN BIRTH IN THE LAST YEAR.**

If yes, please answer the following:

I am _____ weeks/months postpartum; I gave birth on (date): _____

Did you experience any problems during this pregnancy? Y/N (if yes, please specify).

_____

If you had a perineal tear, do you know what grade tear? Y/N _____

If you had a cesarean, was it planned (meaning you did not have labor before the procedure)? Y/N

Are you experiencing problems at the site of cesarean, episiotomy, or perineal tear? Y/N (if yes, please specify). _____

___ **I AM CURRENTLY PREGNANT.**

I am at ___ weeks gestation, with the due date of: _____

I have had concerns during this pregnancy: Y/N (if yes, please specify).

_____

Has your physician placed you on any restrictions? Y/N (if yes, please specify).

_____

Have you experienced any problems during previous pregnancies? Y/N (if yes, please specify). _____

Fill out this section ONLY if you have given birth in the last 12 weeks.	
In the last 7 days:	
I have blamed myself unnecessarily when things went wrong. _____ Yes, all the time. _____ Yes, most of the time. _____ No, not very often. _____ No, not at all.	I have felt panicky or scared for no very good reason. _____ Yes, all the time. _____ Yes, most of the time. _____ No, not very often. _____ No, not at all.
I have been anxious or worried for no good reason. _____ Yes, all the time. _____ Yes, most of the time. _____ No, not very often. _____ No, not at all.	

Pelvic Health History (answer all that apply)

Number of pregnancies____ Number of pregnancy losses ____

Number of vaginal births ____ Number of cesareans ____

Number of episiotomies _____ Number of vacuum/forceps-assisted deliveries _____

Y/N Did you ever experience tearing or need stitches?

Y/N Did you ever have a difficult childbirth or traumatic delivery?

For those with a female anatomical pelvis and/or genitalia, have you ever had the following?

Y/N Pain with vaginal penetration

Y/N Vaginal dryness

Y/N Menopause (if yes, beginning at what age? _____)

Y/N Prolapse or sensation of organs "falling out"

Y/N Pelvic pain

Y/N Painful periods (if yes, beginning at what age? _____)

For those with a male anatomical pelvis and/or genitalia, have you ever had the following?

Y/N Prostate disorders

Y/N Shy bladder

Y/N Pelvic pain

Y/N Erectile dysfunction

Y/N Painful ejaculation

Y/N Other _____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Concerns

Y/N Trouble initiating urine stream

Y/N Urinary intermittent /slow stream

Y/N Trouble emptying bladder

Y/N Difficulty stopping the urine stream

Y/N Trouble emptying bladder completely

Y/N Straining or pushing to empty bladder

Y/N Dribbling after urination

Y/N Constant urine leakage

Y/N Other/describe _____

Y/N Blood in urine

Y/N Painful urination

Y/N Trouble feeling bladder urge/fullness

Y/N Current laxative use

Y/N Trouble feeling bowel/urge/fullness

Y/N Constipation/straining

Y/N Trouble holding back gas/feces

Y/N Recurrent bladder infections

Frequency of urination: during awake hours ____ / day, during sleep hours ____/night

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ☐ Minutes ☐ Hours ☐ Not at all

The usual amount of urine passed is: ☐ Small ☐ Medium ☐ Large

Frequency of bowel movements: ____ times per day, ____times per week, or ___

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? ☐ Minutes ☐ Hours ☐ Not at all

If constipation is present, describe management techniques: _____

_____

Average fluid intake (one glass is 8 oz or one cup): _____glasses per day.

Of this total how many glasses are caffeinated? _____ glasses per day.

Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

SKIP the following questions if there is no leakage/incontinence:

Bladder leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

Bowel leakage - number of episodes

___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

On average, how much urine do you leak?

__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

How much stool do you lose?

__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

What form of protection do you wear? (Please complete only one)

___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? ____ # of pads