NORTHEAST REHABILITATION HOSPITAL NETWORK

Pelvic Floor Medical History Questionnaire
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Rev. 4/21

Patient Name: _____
DOB:_____ MR#_____
MD:_____

Preferred Language _____

Diagnosis:_____

To be completed by your therapist: _____ Therapist initials
Precautions:
_____Cardiac
_____Blood Thinner
_____Diabetes
_____Pacemaker
_____Pregnant, due date:_____
_____Respiratory
_____Blood Pressure
_____Seizure
_____UTI

Onset date of present condition: (month/date/year) _____
Current Medical Problems including Past Surgery, Allergies & Medications**.** *Please discuss with therapist.*
Do you have any neurological problems?:_____

GASTROINTESTINAL:
Yes No Constipation
Yes No Diarrhea
Yes No Heartburn
Yes No Frequent Nausea and/or Vomiting

Yes No Blood in Stool

URINARY:
Yes No Urine Leakage
Yes No Pain with Urination
Yes No Excessive urinating PM
Yes No Bladder Infections

Yes No Kidney Stones

GYNECOLOGICAL: (female)
Yes No Severe cramps w/ period
Yes No Irregular Bleeding/Bleeding between periods
Yes No Heavy Menstruation/Bleeding
Yes No Abnormal Pap Smear
Yes No Ovarian Cysts or Tumors
Yes No Fibroids (Myomas)
Yes No Pelvic Infection (PID)
Yes No Vulvar Pain/Burning
Other: _____

PELVIC: (male & female)
Yes No Pelvic Pain
Yes No Pain with intercourse
Yes No Pain after intercourse
Yes No Sores or Ulcers
Yes No Sexually Transmitted Diseases (herpes, chlamydia, gonorrhea)

PAST OBSTETRICAL HISTORY (if applicable):
How many times have you been pregnant? _____
Of these pregnancies, how many were…
Preterm (premature) deliveries _____
Miscarriages _____
Abortions _____

Weight of largest baby _____
Cesarean _____
Forceps or Vacuum _____

What are your therapy goals? (what do you hope to achieve)_____
_____

UROLOGICAL HISTORY:

How many times do you urinate during the day? _____
How much liquid do you drink per day? _____

How many times do you urinate during the night after you go to sleep? _____
Does the urge to urinate wake you up? YES NO

After emptying your bladder do you have the feeling that you have not yet finished? YES NO

Do you find it difficult to begin urinating? YES NO

Do you experience leakage of urine? YES NO
If yes, how long?_____Months_____Years

Do you leak urine when you cough, sneeze or laugh? YES NO

After you urinate, do you have dribbling? YES NO

Do you leak urine with urgency or on the way to the bathroom? YES NO

Please CIRCLE if you leak urine during the following situations:
Walking Running Urgency Moving from sitting to standing
Lying down Exercise Minimal Activity With Intercourse Straining/Lifting

Do you use a pad for urine leakage? YES NO

When was your last episode of urine leakage? _____

If yes, how many per day and what kind. _____

Do you ever wet the bed while sleeping? YES NO

What amount of leakage do you experience? (Circle)
Drops More than drops Flood Continuous leaking

Do you have sensation or awareness when you experience urine leakage? YES NO

How long can you postpone emptying your bladder when you have the urge to urinate? _____minutes_____hours

BOWEL SYMPTOMS:

How often do you have a bowel movement? _____

Please CIRCLE the bowel symptoms you are experiencing
Diarrhea Constipation Incontinence Laxative Use
Increased Fiber Use Stool Softener Use

Do you strain with a bowel movement? YES NO

After emptying your bowels do you have the feeling that you have not yet finished? YES NO

Difficulty controlling formed stools:
Fecal Soiling YES NO
Liquid Stools YES NO
Flatus/Gas YES NO

Do you push with a finger in the vagina to assist with a bowel movement? YES NO

Additional Comments:

Did you have urinary/bowel problems as a child?_____

1. Have you recently experienced loss of appetite, anxiety/mood changes, or significant weight gain/loss?
   Yes / No..... If yes, please explain:_____
2. Are you experiencing any social or emotional difficulties at home/work that you feel we should be aware of?
   Yes / No..... If yes, please explain:_____
3. Are you experiencing any abuse at home?
   Yes/No If yes, please explain:_____
4. Do you live alone? Yes/No If yes, who can provide care if needed?_____
5. Do you have obstacles in/out of your home? (stairs, clutter, uneven flooring, etc.)….. Yes/No
   If yes, what_____

Patient/Guardian Signature:_____Print:_____Date:_____Time:_____

Clinician Signature:_____Print:_____Date:_____Time:_____