Women's Health Pelvic Floor Dysfunction Past Medical History

PELVIC PMH & SURGICAL HISTORY (check all that apply):

_____ Pelvic Pain
_____ Low Back Pain
_____ Irritable Bowel Syndrome
_____ Thyroid Problems
_____ Appendectomy
_____ Other (describe): _____

_____ Back/Neck Surgery: _____
_____ Gall Bladder Surgery
_____ Kidney Surgery
_____ Ovaries removed
_____ Hysterectomy (__ abdominal, ___ vaginal)

_____ Bladder repair
Hernias

Do you have any problems with your mobility or self care (ex., use a cane, walker, difficulty getting clothes on or off)? Please describe: _____

GYNECOLOGICAL HISTORY:

# of pregnancies _____ # of vaginal deliveries _____ How long did you push? _____
# of episiotomies _____ Do you have a painful episiotomy scar? Y N
# of C-sections _____ When was your menopause onset? _____
Have you been on Hormone replacement therapy? Y N
If yes, Dosage: _____ Type: Pills _____
Estrogen: _____ Progesterone: _____ Patch _____ Cream _____
Do you have a history of urinary tract infections? Y N
Do you have a history of urine loss as a(n) child? Y N adolescent? Y N after child birth? Y N

PREVIOUS TREATMENT FOR INCONTINENCE:

Have you ever done exercises to control urine loss? Y N For how long? _____
Has your doctor prescribed any medications for urine loss? Y N
Have you had any surgical procedures to treat urine loss? Y N

DO YOU EXPERIENCE A LOSS OF URINE WITH:

Coughing, laughing or sneezing?	Y	N
Lifting objects?	Y	N
Exercise, running, etc.?	Y	N
A strong urge to urinate?	Y	N
On the way to the bathroom?	Y	N
"Key in the lock" or other triggers?	Y	N
Just as getting to toilet/removing clothes?	Y	N

Other: _____

DO YOU:

Experience an urge to urinate when you hear water running?	Y	N
And then are you able to get to the toilet?	Y	N
Have difficulty initiating a urine stream?	Y	N
Have difficulty stopping the urine stream?	Y	N
Have burning with urination?	Y	N
Have blood in your urine?	Y	N
Have to strain to empty your bladder?	Y	N
Dribble urine when you are urinating?	Y	N
Dribble after you empty your bladder?	Y	N

WHEN YOU HAVE AN UNCONTROLLED LOSS OF URINE IS IT USUALLY:

_____ A little amount _____ A large amount How many times/day? _____

If you have leakage, what type of protective devices do you use? (Check all that apply)

_____ None
_____ Sanitary pad (maxi)
_____ Incontinence brief
_____ Panty liner
_____ Incontinence pad (____ poise ____ attends ____ serenity)
_____ Other: _____
_____ Sanitary pad (mini)

On average, how many pads do you use each day? _____
Do you soak the pad fully? Y N Do you change the pad each time it's wet? Y N

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VOIDING PATTERNS:

Frequency of urination: # of times/day _____ # of times/night _____

When you have the urge to urinate, how long can you delay before you have to go to the toilet?

_____ Minutes _____ Hours _____ Not at all

Frequency of bowel movements: _____ times/day _____ times/week, or _____

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

Are you ever constipated? Y N

If yes, how do you resolve the constipation? _____

Do you experience diarrhea? Y N How often? _____

Do you use laxatives? Y N Do you use enemas? Y N

Do you have any bowel leakage? Y N If yes, how often? _____

INTAKE:

On average, what is your daily fluid intake (1 glass = 8 ounces)? _____ glasses/day

Of this, how many glasses are caffeinated? _____ glasses/day

Do you restrict fluid because of incontinence (leakage)? Y N

Do you include fiber in your diet (fruit, vegetables, bran, etc.)? Y N

RATE A FEELING OF ORGAN "FALLING OUT"/PROLAPSE OR PELVIC PRESSURE/HEAVINESS:

_____ None present _____ Times per month, during (describe): _____

_____ With standing for _____ minutes or _____ hours

_____ With exertion or straining _____ Other: _____

PSYCHOSOCIAL STATUS:

Living arrangements: Do you live alone? Y N

Occupation: _____

Do you participate in any recreational activities? Y N What? _____

Have you had to restrict your activities due to your problems? Y N

What activities have you restricted? _____

What are your feelings about your urinary or bowel incontinence or pelvic pain on a scale of 1 to 10?

1 2 3 4 5 6 7 8 9 10

no impairments severe impairments

Have you had any changes in intimate relationships/sexual functioning due to your symptoms?

Y N

Signature: _____ Date: _____