



Women's Center for Wellness and Rehabilitation

Evaluation for Urinary Incontinence and Prolapse

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name: _____ Why are you here? _____

Check all the Conditions that apply to you:

HEART/CIRCULATION	v	MEDICAL PROBLEMS	v	CHILDBEARING HISTORY
Heart Disease/Surgery		Diabetes		Are you Pregnant? Yes No If yes, what is your due date: _____
<input checked="" type="checkbox"/> High Blood Pressure				# of Children (circle one number) 0 1 2 3 4 5 +
Pain/tightness in chest		Cancer		# of Vaginal deliveries (circle) 0 1 2 3 4 5 +
Cold Hands/feet		<input checked="" type="checkbox"/> Dizziness		# of C-Sections (circle one number) 0 1 2 3 4 5 +
		Thyroid Problems		# of episiotomies (circle one number) 0 1 2 3 4 5 +
<input checked="" type="checkbox"/> Numbness in hands/feet		<input checked="" type="checkbox"/> Falls the last 6 mos.		# of forceps deliveries 0 1 2 3 4 5 +
		<input checked="" type="checkbox"/> # trips/slips/near falls		Birth weight of largest baby
BONES & JOINTS		<input checked="" type="checkbox"/> Depression		GYNECOLOGICAL HISTORY
Chronic Fatigue Syndrome				Date of Last Pap Smear:
Arthritis				
Fibromyalgia		LUNG/BREATHING		History of Candida/Genital Herpes/ Yeast Yes No
Tailbone pain		Shortness of Breath		Do you have any current infections or yeast Yes No
		Smoke cigarettes now		Do you use Bath salts, vaginal sprays, deodrant Yes No
AREAS OF PAIN		History of smoking		Do you use vaginal lubricants or ___KY jelly Yes No
Back				Do you use latex condoms Yes No
Neck/shoulders		SURGICAL HISTORY		
Rectum		Back or neck		URINARY/BLADDER HISTORY
Abdomen/belly		Tubal Ligation		Do you urinate more than once every 2 hours? Yes No
Vagina		Laproscopy		Do you have a sense of "urgency" to urinate? Yes No
Vulvar area (around the vagina)		Abdominal Hysterectomy		Do leak urine with ___cough ___ laugh ___sneeze ___exercise ___lifting ___Other _____
ALLERGIES		Vaginal Hysterectomy		Do you have interstitial cystitis Yes No
Ragweed		Gall Bladder		How many times do you urinate at night? 1 2 3 4 5+
Food allergies		Bladder surgery		Do you trouble starting a urine stream? Yes No
Latex allergies		Pelvic Surgery		Do you have a falling out feeling ___Yes ___No
Seasonal Allergies		Vaginal Surgery/laser		If yes ___Sometimes with menses ___Standing ___Straining ___At the end of the day ___All the time
SKIN CONDITIONS		Vulvar Surgery		How often do you urinate during the day
Eczema				BOWEL HISTORY
Contact Dermatitis		FAMILY HISTORY		Do you leak gas or feces Yes No
Psoriasis		Skin cancer		Do you have constipation Yes No
Lichens Simplex		Allergies		Is your stool ___Liquid ___Soft (like peanut butter) ___Firm (like banana) ___Hard
Other				How often do you have a bowel movement: ___2 or more x per day ___Daily ___Every other day ___Every 4-7 days

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?



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TELL US HOW YOUR BLADDER PROBLEM AFFECTS YOUR DAILY LIFE?

Please check the appropriate box. If any statement does not apply to you, leave that box blank.

(1) Not at all (2) Slightly (3) Moderately (4) A lot

My bladder problem :	1	2	3	4
Affects the way I dress				
Affects my ability to do my housework (cleaning, shopping, carrying)				
Affects my ability to travel more than one hour without stopping to use the bathroom				
Interferes with my social life (interrupted movies, dancing, going to worship, gatherings)				
Affects my relationship with my partner				
Affects my sex life				
Makes me feel (circle all that apply) depressed anxious embarrassed frustrated angry				
Affects my job or activities outside my home				
Affects my sleep				
Makes me worry that I smell				
Affects the amount of fluids that I drink				

Initial Score ___/44

Score at discharge ___/44

TELL US ABOUT YOUR BLADDER SYMPTOMS

There are five questions. Circle one number 0-4 that most accurately describes your symptoms:

<p><u>How Often do you leak urine?</u></p> <p>0 Never 1 1-4 times per month 2 2-4 times per week 3 Once per day 4 More than once per day</p>	<p><u>How much urine do you leak?</u></p> <p>0 None 1 Few drops 2 Enough to soak a panty liner or underwear 3 Enough to soak a pad or wet outerwear 4 Runs down my leg or wets the floor</p>
<p><u>What type of pads/protection do you wear?</u></p> <p>0 I do not wear any pads or panty liners 1 I wear a panty liner 2 I wear mini pads 3 I wear a maxi pad 4 I wear heavy pads like Depends/Poise or diapers</p>	<p><u>How many pads do you use?</u></p> <p>0 I do not use any pads or panty liners 1 I only use pads during certain activities 2 I use 1 pad per day 3 I use 2-4 pads per day 4 I use more than 4 pads per day</p>
<p><u>How often do you get up at night to urinate?</u></p> <p>0 0-1 time per night 1 1-2 times per night 2 3-4 times per night 3 5-6 times per night 4 More than 6 times per night</p>	<p><u>Activity that Causes Urine Loss</u></p> <p>0 I do not leak with activity 1 Light Activity causes leakage 2 Moderate Activity causes leakage 3 Vigorous Activity causes leakage 4 Leak with all physical effort</p>

Initial Score ___/20

Final Score ___/20



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NUTRITION: How much do you weigh? _____ pounds

Would you like to ___lose or ___gain weight?	Yes No	
Have you gained/ lost more than 10 pounds in the last year?	Yes No	
Are you on any special diet?	Yes No	___Low Carb ___Atkins ___South Beach ___Weight Watchers ___Diabetic ___Other_____
Would you say your diet is "unhealthy"?	Yes No	___too many fast foods ___Not enough vegetables ___High Fat ___High Carb ___Other_____

FLUID INTAKE: What do you drink every day?

___ 8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
 ___ 8 ounce cups of decaffeinated coffee ___ 8-ounce cups/glasses of tea ___ 16-ounce cans of beer
 ___glasses of wine ___glasses of liquor ___ 8-ounce glasses of milk ___ 8-ounce glasses of juice _____
 ___Other_____

Anything else you would like us to know about you? _____

CURRENT SEXUAL ACTIVITY:

___Sexually Inactive due to PAIN ___Sexually inactive due to bladder problem ___Sexually active

If you are sexually active, continue with this section.

___No pain with intercourse ___Pain with intercourse, able to complete coitus ___ Pain with intercourse disrupts or prevents coitus
 ___Pain with intercourse prevents any attempt at coitus

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE YOUR PAIN: _____No Pain or Pain with:

___Gynecological Examination with Speculum ___Urination after intercourse ___Finger insertion into vagina
 ___Tampon insertion ___Tampon removal ___Partner manual stimulation ___Friction with clothing ___Sports activity
 ___Urination in general ___ Wearing pads
 ___Other_____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: _____No Pain or Pain is:

___Hot ___Burning ___searing ___Sharp ___Tiring ___Exhausting ___frightful ___punishing ___Annoying
 ___Troublesome ___miserable ___intense ___unbearable ___discomforting ___Other_____

WHAT MAKES YOUR PAIN BETTER: _____NO Pain or Pain is relieved with:

___Heating pad ___Ice pack ___Resting in bed ___Resting in Chair ___ Medication ___Cream _____
 ___Abstaining from sexual intercourse ___Not using tampons ___Not wearing tight clothes ___other_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ___None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Surgery	Yes No A little
Physical Therapy	Yes No A little	Other	Yes No A little

What started this problem? _____