

**DESERT PHYSICAL THERAPY
WOMEN'S HEALTH QUESTIONNAIRE**

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Please describe your main problem: _____

When/How did it occur? _____

Do you feel your problem is **getting better**, **worse**, or **staying the same**? (Circle one)

What activities are you unable to do or limited in? _____

Date of last physician's appointment: _____ Date of next physician's appointment: _____

Current medications: _____

Have you had any special tests to evaluate your current problem? Yes No
If Yes, please describe: _____

Have you had any pelvic/abdominal surgeries? Yes No
Please list surgeries and when each occurred: _____

Do you have a history of bladder or yeast infections? Yes No
How many per year? _____

Have you gone through menopause? Yes No
If Yes, when? _____

Have you ever been pregnant? Yes No
Vaginal deliveries: _____ # C-sections: _____
Did you have any complications during childbirth? _____
Are you currently pregnant or attempting to get pregnant? _____
If you are pregnant, when is your due date? _____

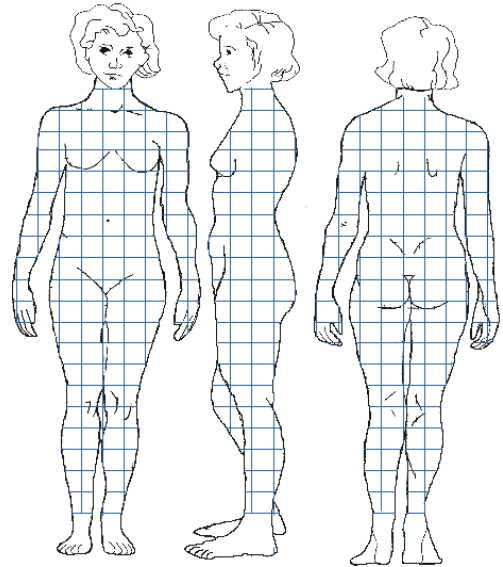
Please make an "X" to indicate if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Fractures	<input type="checkbox"/> Osteoporosis	HABITS:
<input type="checkbox"/> Anemia	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Smoking
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Parkinson's	Packs/day:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	Drinks/week:
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Polio	<input type="checkbox"/> Caffeinated Drinks
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Physical/Sexual Abuse	Drinks/day:
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prosthesis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatoid Arthritis	Please list any other
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Skin Disorder	relevant medical history:
<input type="checkbox"/> Concussion	<input type="checkbox"/> Lung Condition	<input type="checkbox"/> Steroid Use	
<input type="checkbox"/> Depression	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Muscle/Tendon Injury	<input type="checkbox"/> Tumors/Growths	
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Ulcers	

Are you currently working? Yes No **Full Time, Part Time, Light Duty** (Circle One)

Pain History:

Please make an "X" on the diagram over any areas of pain:



Please indicate your average level of pain below:

_____ 10
0 ER Visit
No Pain

Please circle any symptoms you are having listed below:

- Back pain - Muscle/Joint pain - Headache - Pain before/during period
- Pain/burning with intercourse - Pain lasting hours/days after intercourse
- Pain in groin when lifting - Pain when bladder is full - Pain with urination

Please indicate your level of stress below:

_____ 10
0 Extreme Stress
No Stress

Bladder History:

How many times per day do you urinate? _____

Do you ever get up to urinate at night? Yes No

Do you leak urine? Yes No

If Yes, please answer the following questions:

How often? _____

Is it necessary to wear a pad because of urine leakage? Yes No

Please circle which type of pad is worn most often:

Pantishield, Mini Pad, Maxi Pad, Serenity, Diaper

In general, how severe is your urine leakage? (Circle one)

Few drops, Wet underwear, Wet outer wear

What position are you in when you have leakage? (Circle all that apply)

Lying down, Sitting, Standing, Changing position (ex: from sitting to standing)

Do you experience a loss of urine with: (Circle all that apply)

Coughing, Laughing, Sneezing, Lifting objects, Exercise, Jumping

Do you ever have to rush to the toilet because of a strong urge to urinate? Yes No

If Yes, do you ever leak before reaching the toilet? Yes No

Is it ever difficult to begin urinating? Yes No

Do you have to strain to empty your bladder? Yes No

After starting to urinate, do you feel that you could stop the urine flow? Yes No

Do you have regular bowel movements? Yes No

How often? (Circle one) More than once/day, Once/day, 3x/week, Weekly, Other: _____

Are you sexually active? Yes No

Have you ever been taught to do pelvic floor or Kegel exercises? Yes No

What are your personal goals with Physical Therapy? _____