Bon Secours Charity Health System – Pelvic Floor Rehab Patient Health Questionnaire

Name: ___________________________ Date of Birth: ___________________________

Referring MD: ___________________________ Next MD Appointment: ___________________

Would you like a copy of your reports sent to your Primary MD? ☐ Yes ☐ No
If yes: Primary MD Name: ___________________________ Fax: ___________________

Current complaint: ___________________________ Started: ___________________

What is your goal for therapy: ___________________________

Have you had physical therapy in the past for this same problem? ☐ Yes ☐ No

Have you had any physical/occupational/speech therapy visits this year ☐ Yes ☐ No Number if yes: ______

Were you in a hospital or skilled nursing facility within the past 30 days? ☐ Yes ☐ No
If yes, reason for hospital stay _______________ Dates of stay: From: _____________To:_____________

Have you recently received any type of home care services? ☐ Yes ☐ No
What was the last date anyone came into your house for services? ______________________

Past Medical History - Please check all that are applicable:

☐ High Blood Pressure	☐ Stroke	☐ Hepatitis	☐ Heart Attack
☐ HIV/AIDS	☐ Systemic Lupus	☐ Asthma	☐ Depression
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Pacemaker	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Tuberculosis	☐ Latex Allergy	☐ Currently Pregnant
☐ Osteoarthritis	☐ Angina	☐ Osteoporosis	Other: ______________

☐ Cancer - Location(s) and Date(s): ___________________________

Number of pregnancies ___________________ Number of vaginal deliveries___________________

Birth weight of largest baby___________________ Number of cesarean deliveries___________________

Number of episiotomies___________________ Date of last pap smear___________________

Did you have any trouble healing after delivery? ☐ Yes ☐ No Do you have a regular periods? ☐ Yes ☐ No

Do you have frequent urinary infections? ☐ Yes ☐ No Any history of sexual abuse/trauma? ☐ Yes ☐ No

Over the past 12 months, have you fallen 2 or more times? ☐ Yes ☐ No

Over the past 12 months, have you had 1 or more falls that resulted in injury? ☐ Yes ☐ No

Do you smoke/use smokeless tobacco products? ☐ Yes ☐ No I smoke_____ packs per day
I use smokeless products ________ times per day. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many per day? _______ How many per week? _________

Please list any current medications with dosages you are presently taking (including prescription, over-the-counter, herbals, vitamins, minerals, dietary or nutritional supplements).

Medication	Dosage	Medication	Dosage
______________	______________	______________	______________
______________	______________	______________	______________

☐ Please see attached copy of medication list provided by the patient. ☐ I am not taking any medication.

Name: ______________________________

Test Results:

X-rays, CT scans, or MRI ☐ Yes ☐ No Results: ______________________________
Urodynamics test ☐ Yes ☐ No Results: ______________________________
Cystoscope ☐ Yes ☐ No Results: ______________________________
Urine test ☐ Yes ☐ No Results: ______________________________
Bowel test ☐ Yes ☐ No Results: ______________________________

Do You Have Pain With- please check all that are applicable:
☐Tampon Use ☐Pelvic Exam ☐Sexual Intercourse ☐Urination ☐Full Bladder ☐ Bowel movement
☐Back, leg, groin, abdominal-if yes where: ______________________________

Bladder Symptoms- Do you lose urine when you- please check all that are applicable:
☐Cough, sneeze, laugh ☐ Lift, exercise, dance, jump ☐Push up to standing ☐On way to the bathroom
☐Have a strong urge to urinate ☐ Hear running water ☐ Other:______________________________

Do You- please check all that are applicable:
☐ Wet the bed ☐ Have a falling out feeling ☐ Strain to empty your bladder ☐ Unable to empty bladder fully ☐ Have difficulty starting a stream of urine ☐ Have a strong urge to urinate ☐ Urinate more than 7 times/day

Bowel Symptoms- please check all that are applicable:
☐ Strain to have a bowel movement ☐ Include fiber in your diet ☐ Take laxatives/enema regularly
☐ Have strong urge to move bowels ☐ Leak/stain feces ☐ Leak gas by accident ☐ Have diarrhea often

How often do you move your bowels: ________ per day/week (please circle)
Most common consistency (please circle): liquid soft firm pellets fluctuates

Pelvic floor rehabilitation is a specialized field of physical therapy and may require an internal exam for a thorough diagnosis and treatment to be successful. An additional consent form for allowing the internal exam must be signed for a complete evaluation to be performed. The pelvic floor rehab therapists are all female and will maintain your privacy as much as possible by being in a private room or completely behind an enclosed curtained space if reasonable.

Do I feel safe at home? ☐Yes ☐No If no, reason why: ______________________________

Please let us know how you heard about our facility: ☐ Sign ☐ Insurance Directory ☐ I was a previous patient ☐ From previous patient (please specify) ________________ ☐ Dr. ______________________________
☐ Other: ______________________________

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Patient or Authorized Representative Signature: ______________________________ Date: ____________

Therapist Signature: ______________________________ Date:__________________