

Please check all medical problems that you have or have had in the past:

- | | | |
|---|--|--|
| <input type="checkbox"/> Shoulder/Wrist/Elbow Pain | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Pain with Intercourse |
| <input type="checkbox"/> Hip/Knee Pain | <input type="checkbox"/> Pelvic/Vulvar Pain | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Neck/Middle Back Pain | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Multiple Births |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ovarian Cysts or Uterine Fibroids |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Urinary or Vaginal Infections | <input type="checkbox"/> Placenta Previa |
| <input type="checkbox"/> Frequent or Severe Headaches | <input type="checkbox"/> Swelling in Hands/Feet/Face | <input type="checkbox"/> Unusual Vaginal Bleeding |
| <input type="checkbox"/> Groin Pain | <input type="checkbox"/> Uterine Prolapse | <input type="checkbox"/> Rectocele/Cystocele |
| <input type="checkbox"/> Sacroiliac Pain | | |

Please check all previous surgeries/date of surgery:

- | | |
|---|-------------|
| <input type="checkbox"/> Hysterectomy: <input type="checkbox"/> Abdominal <input type="checkbox"/> Vaginal <input type="checkbox"/> Ovaries removed | Date: _____ |
| <input type="checkbox"/> Hernia Repair | Date: _____ |
| <input type="checkbox"/> Appendectomy | Date: _____ |
| <input type="checkbox"/> Gallbladder | Date: _____ |
| <input type="checkbox"/> Back/Neck Surgery | Date: _____ |
| <input type="checkbox"/> C-Section | Date: _____ |
| <input type="checkbox"/> Kidney Surgery | Date: _____ |
| <input type="checkbox"/> Bladder Repair | Date: _____ |
| <input type="checkbox"/> Other | Date: _____ |

Do you have any pain with sexual activity or urination? _____

Last menstrual period (onset)? _____

Last pelvic exam? _____

Hormone Replacement Therapy? Yes No

Check any that apply: Pill Patch Cream Estrogen Progesterone

Have you ever been taught how to do Kegal exercises? Yes No

Occupation/Job Duties: _____

Obstetric History:

How many children do you have? _____

If pregnant, due date: _____ Number of Weeks Gestation: _____ Number of Previous Pregnancies: _____

Number of Vaginal Deliveries: _____

Number of C-Sections: _____

Date: _____

Date: _____

Episiotomy or tearing during delivery: Yes No

Painful Episiotomy/C-Section Scar? Yes No Other Painful Incisions? _____

Complications this or prior pregnancies? _____

Level of exercise prior to pregnancy: Sedentary Light Active Very Active Now: _____

I HAVE REVIEWED THIS FORM AND WILL UPDATE THE INFORMATION AS CHANGES OCCUR:

THERAPIST SIGNATURE: _____ DATE: _____ LICENSE #: _____

LEE MEMORIAL HEALTH SYSTEM
Lee County, Florida
Rehabilitation Services
WOMEN'S HEALTH MEDICAL HISTORY
AND STATUS QUESTIONNAIRE

Bladder Habits – Please check all that apply:

- Frequent Urinary Tract Infections
- Strong urge to urinate produces involuntary loss
- Loss of urine on the way to the bathroom
- Urgency when you're cold or hear running water
- Loss of urine with cough, sneeze, lifting, exercise, running
- Loss of urine upon arriving at bathroom
- Difficulty initiating urine stream
- Difficulty stopping urination
- Pain with urination
- Blood in urine

Number of voids/day: _____ Number of voids/night: _____ Number of episodes of involuntary urine loss/day: _____

Amount of loss: No Leakage Few Drops Continuous Dribbling Wet Underwear Wet Outerwear

How long can you delay the need to urinate? . . . 1-2 minutes 15 minutes 1+ hours Unable
 Less than 10 minutes 1/2 hour Indefinitely

Bed Wetting: Yes No

Do you use protective devices? Yes No If Yes, Type and number of pads/day: _____

Do you restrict your fluid intake because of urinary leakage? Yes No

Number of cups caffeinated and/or carbonated beverages/day: _____ Number of cups of juice/day: _____

Number of cups of water/day: _____

Have you ever taken medication to prevent urine loss? Yes No _____

Attitude towards problem: No Problem Minor Inconvenience Slight Problem
 Moderate Problem Major Problem

Bowel Habits

Do you have any gastrointestinal disease: No Yes: _____

Are you frequently constipated: Yes No

How do you resolve this? High Fiber Diet Laxatives Enemas

Do you frequently have diarrhea: Yes No

Do you notice blood in your stool? Yes No Often? Yes No Hemorrhoids? Yes No

Do you have rectal pain: No Yes: At rest Sharp, fleeting pain With bowel movement

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 Lee County, Florida
 Rehabilitation Services
WOMEN'S HEALTH MEDICAL HISTORY
AND STATUS QUESTIONNAIRE
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UCO TAB - REHAB: PT, OT, ST