JCAHO COMPLIANT EVALUATION FOR FEMALE PELVIC DYSFUNCTION

Physical Therapy Department - SELF REPORTED MEDICAL HISTORY

Name:___________________________________ Age: _______________ Today's date:_________________

Why are you coming for therapy? ____

MEDICAL CONDITIONS: (check all that apply and add others not on the list)

	Heart problems		Anemia		Osteoporosis		Low Back Pain
	High Blood Pressure		Breast Cancer		Kidney disease		Tail bone/sacroiliac pain
	Ankle swelling		Ovarian/Uterine Cancer		Night pain/night sweats		Neck or jaw pain
	Smoking currently		Vision/hearing problems		Sexually transmitted disease		Pudendal Nerve Irritation
	Smoking history		Epilepsy/seizures		Hepatitis HIV/Aids		Birth control used: __None __IUD __Pills __Condom
	Stroke		Diabetes		Unexplained muscle weakness		
	Breathing difficulty		Depression*		Unexplained tiredness		Digestive problem
	Numbness/tingling		Hyper/Hypo thyroid		Chronic Fatigue/Fibromyalgia		
	Falls, trips or slips*		Headaches/migraines		Bone fractures		
	Dizziness/fainting*		Anorexia/bulimia		*Reviewed by & date*		

SURGERIES: (check all that apply and add others not on the list)

SURGERY	Year	SURGERY	Year	SURGERY	Year	SURGERY	Year	Other
Neck		Hysterectomy		Cardiac bypass		Gall Bladder		
Back		Episiotomy		Cardiac Stents		Appendectomy		
C-Section #__		Bladder surgery		Pacemaker		Joint Replacement		
Vaginal Delivery#_		Rectocele repair		Hernia repair		Removal of Adhesions		
Miscarriage		Breast Surgery		Laproscopy	*Reviewed by & date*			

ALLERGIES: (List all that apply)

MEDICATION ALLERGIES	OTHER ALLERGIES	FOOD ALLERGIES
	☐ Latex ☐ Oils/lotion	
	☐ Band aid/surgical tape	
		Reviewed by & date

MEDICATION LIST (please list name, dose and the reason you are taking a medication, include non prescription medications, vitamins and herbal medications). CONTINUE ON THE BACK OF THIS PAGE IF YOU NEED TO.

Name of Medication	Dose	Reason for taking	Name of Medication	Dose	Reason for taking
1			5		
2			6		
3			7		
4			*Reviewed by & date:*		

Month				Year		
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Month				Year		
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Month				Year		
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Initial date/month health history was reviewed – at least every 90 days

Section A: **BLADDER RELATED SYMPTOMS: (If you do not have any bladder symptoms, skip Section A)**

√	Difficulty Voiding	√	Bladder Pain	√	Bladder History
	Trouble initiating urine stream		Painful urination		Blood in urine
	Intermittent/slow urinary stream		Discomfort in the bladder		Frequent bladder infections
	Trouble emptying bladder		Pain with bladder filling		Falling out of the bladder (cystocele)
	Straining or pushing to empty bladder		Pain relief after voiding		Pelvic Pressure/heaviness
	Can't feel urge/bladder fullness				Interstitial Cystitis
	Dribbling after urination				Childhood bladder problems

	URINARY FREQUENCY/URGENCY **(If you have urgency/frequency, please answer the following questions)**
How often do you urinate during the day _____times/day OR every _____hours	
How often do you wake up at night to urinate? _____times/night	
When you feel the urge to urinate, how long can you delay before you "just have to go"? ____minutes ___hours	
Usually, the amount of urine passed is _____small ____medium ____quite a lot	

	URINARY LEAKAGE **(If you have urinary leakage, please answer the following questions)**
What causes leakage? ____cough ___sneeze __exercise ___daily activities ___other_____	
How long have you had leakage? ____months ____years ___other _____	
What started the leakage? ____ I don't know OR _____	
Is leakage associated with a strong desire to urinate? ___ yes ____no	
How often do you leak? ____times/day ____times/week ___times/month ___only with some activities	
On average, how much urine do you leak? __a few drops ___wets underwear ___wets outerwear ___wets floor	
What protection do you wear? ___none ___ tissue paper/panty shield ___maxi pad/absorbent pad ____diaper	
What treatment have you had for this problem:	
Therapist's comments	

Section B: BOWEL RELATED SYMPTOMS: (If you do not have any bowel symptoms, skip Section B)

√	Voiding Difficulty	√	Pain	√	Bowel History
	Constipation		Bowel Discomfort/pain		Falling out of the bowel (rectocele)
	Diarrhea		Pain with defecation		Pelvic Pressure/heaviness
	Straining to empty bowels				Irritable bowel syndrome
	Trouble feeling bowel fullness				Diverticulitis
	Trouble feeling urge to move bowels				Childhood bowel problems
	Can't empty bowels fully				

	BOWEL FREQUENCY/URGENCY/CONSTIPATION
How often do you have a bowel movement? _____times/day OR ____times/week OR ___ other _____	
When you feel the urge to have a bowel movement, how long can you delay before you go? ____minutes ___hours ___ not at all	
Usually, the stool is ___hard/pellets ___ thin/pencil like ___firm/like banana ___soft like peanut butter ____watery	
If you have constipation, how are you helping yourself? ___laxatives ___fiber/diet ___drink more fluids ___use hand to empty bowels ___other _____	
How long have you had this problem? ____months ____years ____other _____	
	LEAKAGE OF STOOL OR LEAKAGE OF GAS (If you have bowel or gas leakage, please answer the following questions)
Is leakage associated with a strong desire to have a bowel movement? ___ yes ____no	
How often do you leak? ____times/day ____times/week ___times/month ___only with some activities	
On average, how much stool do you leak? __stain underwear ___small amount in underwear ___ complete emptying	
What protection do you wear? ___none ___ tissue paper/panty shield ___maxi pad/absorbent pad ____diaper	
How long have you had this problem? ____months ____years ____other _____	
What started the leakage? ____ I don't know OR _____	
What treatment have you had for this problem:	
Therapist's comments	

Section C: PELVIC PAIN RELATED SYMPTOMS: (If you do not have pain symptoms, skip Section C)

√	VAGINAL PAIN	√	PELVIC DISCOMFORT	√	GYNECOLOGICAL HISTORY
	Painful sex with penetration		Pain in tailbone		Yeast infections
	Painful sex with deep thrust		Pain in low back/sacro iliac pain		Candida
	Pain hours after sexual penetration		Vulvar Pain/Vestibulitis		Prolapsed uterus
	Pain with insertion of speculum		Pelvic Pain		Menopause _____years
	Pain with finger insertion into vagina		Burning in perineal area		Menstrual pain/problems
	Pain with tampon insertion		Rectal Pain		Endometriosis
	Pain with tampon removal				Adhesions
					Vaginal dryness

SEXUAL PAIN/DISCOMFORT

Please check the statement that best describes your current level of sexual activity

___ sexually active without any discomfort ___Pain with intercourse but able to complete coitus

___ Pain with intercourse prevents completion of coitus ____Pain with intercourse prevents any attempt at coitus

___ Not sexually active due to not being in a relationship at this time ___Not sexually active for other reasons

___ Lack sexual desire/no interest in sex

How long have you had pain/discomfort? ____months ____years

Have you ever had sex/vaginal penetration that was not painful? ____yes ___no

On a scale of 0-10 (with 10 being the worst possible pain) rate the pain you have with penetration into the vagina ___/10

Describe the pain ____burning ___stinging ___unbearable ___Other _____

OTHER PERINEAL PAIN/DISCOMFORT (Check all the statements that describe your symptoms)

I have pain/discomfort with the following:

____ friction with underwear ___wearing tight pants ___pain with sitting ___wearing pads ___using tampons

____ removing tampons ____ partner/self manual stimulation ___ when I am stressed/anxious pain seems worse

What treatment have you had for this problem:

Therapist's comments

SECTION D: (all patients need to complete this Section)

Check Activities you have difficulty with:

	DIFFICULTY WITH ACTIVITES OF DAILY LIVING	DESCRIBE LEVEL OF DIFFICULTY
	Sitting	___minutes before pain makes me move
	Standing	___minutes before I have to change position/sit
	Walking for daily activity (e.g. grocery store)	
	Walking for exercise or general exercises	
	Light housework	
	Heavy housework	
	Child care	
	Working or driving to work	
	Changing positions (sit to stand, lying to sitting)	
	Social life is restricted because of this problem	
	Difficulty with relationship/sexual activity	
	Other	

MEDICAL EXAM	
When did you last see a physician?	Date:
What tests were performed	___PAP ___Mammogram ___Blood work _ other
How would you describe your general health	___ Excellent ___Good ___Fair ___Poor ___very poor

HOME LIFE/ WORK LIFE	
Occupation:	How many hours per week do you work?
Activity Restrictions, if any	
Most of the day, I ☐ Sit ☐ Stand ☐ Walk ☐ Other:	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow	
Do you feel safe at home? ☐ Yes ☐ No	How many people live with you at home?

NUTRITION/HYDRATION	
What is your body weight at this time?	_____lbs.
Describe your diet	__ high protein __high carbs __high fat ___fast foods __balanced ___high/adequate fiber
Are you on a special diet? ___yes ___No	__diabetic __ High Protein _ Weight watchers __Other:
Describe what you drink per day	__water glasses __diet drinks __sugared soft drinks __tea __ decaf coffee cups __regular coffee cups __alcohol ___other:

EXERCISE/ACTIVITY LEVEL	
Describe your general level of activity	___sedentary __somewhat active __very active
How many times per week do you exercise	___Zero ___1-2x/ week ___3-4x/week ___5+days/week
Describe the exercises you do	

FEELINGS	
Do you feel depressed?	_____yes ___no ___don't know ___sometimes
How much stress do you feel in your life?	___ High level of stress ___ Medium ___Low
General mood (example: happy, tired, content, optimistic, lethargic, motivated or other)	

LEARNING PREFERENCE	
How do you learn best	___ by reading/watching __listening ___doing

Therapists comments: