Kona Rehab
PHYSICAL THERAPY

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Pelvic Health – Subjective Medical History

Patient Name:		Date:
Birthdate:	Occupation:	
Referred by:	Primary Care Physician:	

Please fill in the answers to the best of your ability. Your therapist will review the answers with you during your Evaluation

History of present condition:

1. Describe your primary issue: ______
2. When did your symptoms begin? ______
3. Which of the following ***best describes*** how your condition started:
   Childbirth   A fall   After surgery   Lifting   During recreation/sports
   Running   Trauma   Unknown   Other
   If *other*, please explain: ______
   Since onset, are your symptoms getting: Better   Worse   Not changing
4. Which of the following best describes the nature of your symptoms? (Check *ALL* that apply):
   N/A   Constant   Occasional   Stabbing   Throbbing
   Sharp   Shooting   Cramping   Itching   Tender
   Aching   Hot/burning   Dull   Other: ______
5. Describe activities that you cannot perform because of your condition: ______
6. Are you taking any medications for your *current* symptoms?   Yes   No
   If yes, please list: ______
7. What are your goals for treatment? ______

Obstetrical/Gynecological History

1. Last pelvic exam (Month/Year): ______
2. Last Urinalysis (Month/Year): ______
3. Other special tests (Specify: Type, Date, Results): ______
4. Are you sexually active?   Yes   No
5. Please describe any pain or issues with sexual activity: ______
6. Have you ever been sexually abused?   Yes   No
7. What stage of menopause are you in?   N/A
   Premature ovarian failure   Peri Menopause   Menopause   Post
8. Do you have:
   Vaginal dryness?   Yes   No
   Abnormal or irregular bleeding?   Yes   No
   Painful Periods?   Yes   No
9. History of, or present sexually transmitted diseases: Yes   No
   If *yes*, please list the type: ______

10. Are your currently pregnant or attempting pregnancy? Yes No
11. # of pregnancies (Please include the year): ______________________________
12. # of vaginal deliveries: ______________ Weight of largest baby: ______________
13. # of Cesarean deliveries: ______________ Weight of largest baby: ______________
14. Episiotomies/tearing? ______________ Trouble healing after childbirth? ______________
15. Describe any complications and/or trouble healing after childbirth: ______________

Bladder Symptoms

1. Do you have any of the following? (Check *ALL* that apply): N/A – Skip to question #5
   Difficulty initiating a stream of urine | Pain with full bladder | Blood in urine
   Frequent toileting to avoid problems | Dribbling after stream ends
   Pain/burning during urination | Weak/slow/intermittent stream of urine
2. Occurrence of incontinence or leakage: ______Times per day ______Times per night ______Times per week ______Times per month
3. Severity of leakage: No leakage | Few drops | Wets underwear | Wets outerwear | Wets floor
4. Position or activity with leakage (Check *ALL* that apply): No leakage
   Lying down | Sitting | Standing | Walking | Running
   Jumping | Lifting | Coughing | Sneezing | Laughing
   Sexual activity | Strong Urge | When constipated
   Changing positions | On the way to the toilet | Other ______________
5. Rate a feeling of organ "*falling out*"/ Prolapse or pelvic heaviness/pressure:
   Never | Occasionally/with period | At the end of the day
   Pressure with straining | Pressure with standing | Pressure all day
6. How long can you delay the need to eliminate?
   Indefinitely | 1 + hours | 30 minutes | 15 minutes | Less than 10 min | 1-2 min | Not at all
7. Ability to stop urine flow:
   Can stop completely | Can partially deflect urine stream
   Unable to deflect/slow the stream | Other: ______________
8. Do you have (Check *ALL* apply): Trouble emptying bladder completely
   Strain/push to empty bladder | Constant urine leak | Dribble after urination
   Recurrent bladder infections | Trouble feeling bladder urge/fullness
9. Fluid intake: ______8oz glasses per day
   Caffeinated beverages: ______8oz glasses per day

Bowel Symptoms *(Only complete if you are experiencing bowel symptoms)*

1. Do you have any of the following? (Check *ALL* that apply) N/A – Skip to question 4
   Constipation/strain to have a bowel movement | Have pain with bowel movement
   Leak/stain feces | Have diarrhea often | Leak gas by accident
   Include fiber in diet | Take laxative/enemas/stool softener regularly | Hemorrhoid's
2. Occurrence of bowel leakage: ______Only with exertion or strong urge
   ______Times per day ______Times per week ______Times per month
3. Severity of bowel leakage: Stool Staining | Small amount in underwear | Complete Emptying

4. How often do you have a *regular* bowel movement? ______Per day ______Per week
5. If constipation is present, describe management techniques: ______________________________
6. Most common stool consistency: Liquid Soft Firm Pellets
   Other: If you answered *other*, please explain: ______________________________
7. How long can you delay the need to eliminate?
   Indefinitely 1 + hours 30 minutes 15 minutes
   Less than 10 min 1-2 minutes Not at all

Pain *(Only complete if your experiencing pain)* **"0"- No pain "5"- Moderate "10"- Excruciating**

1. Please rate your pain: __________
2. Area of pain (Check *ALL* that apply): Back Leg Groin Stomach
   Other: ________________
3. Is the pain present when you are? Lying still Changing Positions Both
4. Does your pain wake you at night? Yes No
5. What aggravates your symptoms? (Check *ALL* that apply) Sleeping Lying
   Sitting Squatting Standing Going to/from sitting
   Walking Menstruation Sexual Activity Sustained Bending
   Deep breathing Coughing/sneezing
   Exercises, including: ______________________ Other: ______________________
   Repetitive activities including: ______________
6. What relieves your symptoms? (Check *ALL* that apply) Sitting Stretching
   Standing Heat Cold Massage Rising from sitting
   Exercise Rest Medication Walking Lying down
   Nothing Other ______________________________

Medical History

1. How would you rate your general health? Excellent Good Average Fair Poor
2. How often do you exercise outside of normal daily activities? ______________________
3. Do you smoke tobacco? Yes No
4. If you answered *yes*, how much per day? ______________________________
5. List any past surgeries with dates of operation

Type of Surgery	Date of Surgery

To the best of my knowledge and belief, the information I have provided is complete and true.
I hereby give my consent to receive therapy services at Kona Rehab.

Patient Signature: ______________________ Date: __________

Reviewed by: ______________________ Date: __________