foundational concepts

4700 Belleview Ave, Ste 415 Kansas City, MO 64112 Phone (816) 569-2802 Fax (816) 569-5436

Medical History Questionnaire

Name: _____ Birthdate:_____

Height: _____ Weight: _____

Describe the current problem?_____

_____

When did the problem begin? _____

Has the problem stayed the same? Getting better? Getting worse?

Do you have pain? Y/N Please rate pain 0-10: _____ (0 is no pain, 10 is horrible pain) Please describe the type of pain: _____

Have you had previous treatments?_____

Have you fallen in the past year? _____ How many times? _____

Pain

Y/N Pain wearing tight clothing?

Y/N Pain with sitting?

Y/N Pain with bowel movement?

Y/N Pain with speculum exams?

Y/N Pain with sexual intercourse?

Y/N Pain worsens with walking?

Y/N Require pain medication?

Y/N Limited social outings due to pain?

Y/N Pain inserting tampon?

Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than _____ minutes

___ Walking greater than _____minutes

___ Standing greater than _____ minutes

___ Changing positions (i.e. - sit to stand)

___ Light activity (light housework)

___ Vigorous activity/exercise (run/weight lift/jump)

___ Sexual activity

___ With cough/sneeze/straining

___ With laughing/yelling

___ With lifting/bending

___ With cold weather

___ With triggers -running water/key in door

___ With nervousness/anxiety

___ No activity affects the problem

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What relieves your symptoms?_____

How has your lifestyle/quality of life been altered/changed because of this problem?

_____

Social activities (exclude physical activities), specify_____

Diet /Fluid intake, specify _____

Physical activity, specify _____

Work, specify _____

Other _____

Rate the severity of this problem from 0 -10 (0 being no problem and 10 being the worst) _____

What are your treatment goals/concerns?_____

_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling

Y/N Other /describe_____

_____

Health History: Date of Last Physical Exam _____ Tests performed_____

_____

General Health: Excellent Good Average Fair Poor **Occupation:** _____

Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Mental Health: Current level of stress High ___Med___ Low____ **Current psych therapy?** Y/N

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe _____

Have you ever had any of the following conditions or diagnoses? Circle all that apply /describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #_	Y/N	Vaginal dryness
Y/N	Episiotomy #__	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? __
Y/N	Difficult childbirth #___	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain

Y/N Other /describe_____

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe_____		

Medications - pills, injection, patch Start date/dosage Reason for taking

_____

_____

_____

_____

Over the counter -vitamins etc. Start date/dosage Reason for taking

_____

_____

_____

_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Pain with bowel movement	Y/N	Pain with sexual intercourse
Y/N	Trouble emptying with bowel movement	Y/N	Smearing of feces in underwear
Y/N	Leaking of feces	Y/N	Feelings of bloating or gassiness
Y/N	Abdominal pain		

Frequency of urination: awake hour's ____ times per day,
sleep hours ____times per night

When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
_____minutes, _____hours, _____ not at all

The usual amount of urine passed is: ___small ___ medium___ large.

Frequency of bowel movements: _____ times per day, _____times per week.
Do you have a regular bowel schedule? Y/N

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.

If constipation is present, please describe management techniques _____

What is the consistency of bowel movements: Hard, Soft Solid, Soft not solid

Average fluid intake (one glass is 8 oz. or one cup) _____ glasses per day.

Of this total how many glasses are caffeinated?_____ glasses per day.

Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present

___Times per month (specify if related to activity or your period)

___With standing for _____ minutes or _____hours.

___With exertion or straining

___Other

Skip this page if you don't experience leakage/incontinence

Bladder leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with physical exertion/cough

Bowel leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with exertion/strong urge

On average, how much urine do you leak?

__ No leakage

__ Just a few drops

__ Wets underwear

__ Wets outerwear

__ Wets the floor

How much stool do you lose?

__ No leakage

__ Stool staining

__ Small amount in underwear

__ Complete emptying

__ Is the stool formed or loose?

What form of protection do you wear? (Please complete only one)

___None

___Minimal protection (Tissue paper/paper towel/pantishields)

___Moderate protection (absorbent product, maxipad)

___Maximum protection (Specialty product/diaper)

___Other _____

On average, how many pad/protection changes are required in 24 hours? _____ # of pads