Rex Healthcare
Raleigh, NC 27607

RexOutpatient Rehabilitation- Pelvic Health Physical Therapy

A Department of Rex Hospital

SELF REPORTED MEDICAL HISTORY

Name:_____ **Age:** _____ **Date:**_____

CONSENT: (please read and sign below)

I understand that I have been referred to pelvic floor physical therapy. To evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. The examination and some physical therapy treatments are performed by observing and/or palpating the perineal region including the vagina and/or rectum. As a patient it is my option to have a 3rd party in the room during the pelvic floor muscle evaluation and/or treatment.

I choose to have a 3rd party present during my exam: ☐ No ☐ Yes Patient Signature:_____

Why are you coming for therapy? _____

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

	Heart problems		Anemia		Chronic fatigue/fibromyalgia		Prostate cancer
	High blood pressure		Osteoporosis		Low back pain		Prostatitis
	Ankle swelling		Kidney disease		Night pain/night sweats		BPH (enlarged prostate)
	Smoking currently		Vision/hearing problems		Arthritis		Bladder Infection
	Smoking history		Epilepsy/seizures		Hepatitis/HIV		Breast cancer
	Stroke		Diabetes		Unexplained muscle weakness		Ovarian/uterine cancer
	Breathing difficulty		Depression		Sexually transmitted disease		Other:
	Numbness/tingling		Hyper/hypo thyroid		Pudendal nerve irritation		
	Falls, trips or slips		Headaches/migraines		Digestive problems		
	Dizziness/fainting		Anorexia/bulimia		Tail bone/sacroiliac pain		

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

SURGERY	Year	**SURGERY**	Year	**SURGERY**	Year	**SURGERY**	Year
Neck		Cardiac bypass		C-section #:		Prostatectomy	
Back		Cardiac stent		Vaginal delivery #:		Removal of adhesions	
Joint replacement		Pacemaker		Miscarriage		Other:	
Appendectomy		Hernia repair		Breast surgery			

ALLERGIES: (List all that apply)

MEDICATION ALLERGIES	OTHER ALLERGIES	FOOD ALLERGIES
	☐ Latex ☐ Lotion/oils/gel	

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.			4.		
2.			5.		
3.			6.		

HOME/WORK LIFE:

Occupation:	
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Do you feel safe at home and in your relationships? Yes ☐ No ☐
Do you feel safe at home? ☐ Yes ☐ No	How much stress do you feel in your life? High ☐ Medium ☐ Low ☐
Do you feel depressed? ☐ Yes ☐ No	Describe your general mood:

DAILY ACTIVITIES: check activities you have difficulty with:

☐ Sitting	☐ Housework	☐ Changing position
☐ Standing	☐ Child care	☐ Social activities
☐ Walking	☐ Driving	☐ Other:

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

√	Difficulty Voiding	√	Pain	√	Bowel History
	Constipation		Bowel discomfort/pain		Falling out bowel (rectocele)
	Diarrhea		Pain with defecation		Irritable bowel syndrome
	Straining to empty bowels		Pain after defecation		Diverticulitis
	Trouble feeling bowel fullness				Pelvic pressure/heaviness
	Trouble feeling urge have BM				Childhood bowel problems
	Can't empty bowels fully				

BOWEL FREQUENCY/URGENCY/CONSTIPATION

1. How often do you have a bowel movement? ____times/day OR ____times/week OR ____other:
2. When you feel the urge to have a bowel movement, how long can you delay before you go? ____minutes ____hours ☐ Not at all
3. Usually, the stool is: ☐ Hard/pellets ☐ Thin/pencil like ☐ Firm ☐ Soft ☐ Watery
4. If you have constipation, how are you helping yourself? ☐ Laxatives ☐ Fiber/diet ☐ Drink more fluids ☐ Use hand to empty bowels ☐ Other:
5. 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)

6. Is leakage associated with a strong desire to have a bowel movement? ☐ Yes ☐ No
7. How often do you leak? ____times/day ____times/week ____times/month ☐ Only with some activities
8. On average, how much stool do you leak? ☐ Stain underwear ☐ Small amount ☐ Complete emptying
9. What protection do you wear? ☐ None ☐ Tissue paper/panty shield ☐ Maxi pad/absorbent pad ☐ Diaper
10. How long have you had this problem? ____months ____years ☐ Other:
11. What started the leakage? ☐ I don't know OR:

What treatment have you have for this problem:

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

√	Difficulty Voiding	√	Bladder Pain	√	Bladder History
	Trouble initiation urine stream		Painful urination		Shy bladder
	Intermittent/slow urinary system		Discomfort in bladder		Blood in urine
	Trouble emptying bladder		Pain with bladder filling		Frequent bladder infections
	Straining/pushing to void		Decreased pain after voiding		Pelvic pressure/heaviness
	Dribbling after urination				Falling out of bladder (cystocele)
	Can't feel urge/bladder fullness				Intersitial cystitis

URINARY URGENCY/ FREQUENCY: (If you have urgency/frequency please answer the following questions)

1. How often do you urinate during the day? _____times/day OR every _____hours
2. How often do you wake up at night to urinate? _____times/night
3. When you feel the urge to urinate, how long can you delay before you "just have to go"? ____minutes ____hours
4. Usually, the amount of urine passed is: ☐ Small ☐ Medium ☐ Quite a lot
5. Do you "hover" over the toilet? ☐ Yes, when I use public restrooms ☐ No, I sit down on the toilet seat
6. Describe what you drink per day: ☐ Water ☐ Diet drinks ☐ Tea ☐ Coffee ☐ Decaf Coffee ☐ Alcohol ☐ Soda ☐ Other:
7. Are you on a special diet? ☐ No ☐ Yes ☐ Describe:

URINARY LEAKAGE: (If you have urinary leakage, please answer the following questions)

1. What causes leakage? ☐ Cough ☐ Sneeze ☐ Exercise ☐ Daily activities ☐ Other:
2. What started the leakage? ☐ I don't know ☐ Other:
3. How long have you had leakage? ____months ____years ☐ Other :
4. Is leakage associated with a strong desire to urinate? ☐ Yes ☐ No
5. How often do you leak? ____times/day ____times/week ____times/month ___ Only with some activities
6. On average, how much urine do you leak? ☐ Drops ☐ Wets underwear ☐ Wets outerwear ☐ Wets floor
7. What protection do you wear? ☐ None ☐ Tissue paper/panty shield ☐ Maxi pad/absorbent pad ☐ Diaper

What treatment have you have for this problem:

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

√	PELVIC DISCOMFORT	√	FEMALE SPECIFIC	√	MALE SPECIFIC
	Pudendal Neuralgia		Painful sex with penetration		Pain with sexual activity
	Pudendal Nerve Entrapment		Painful sex with deep thrust		Painful ejaculation
	Pain in tailbone		Pain hrs after sexual penetration		Erectile discomfort
	Pain in low back/sacro-iliac pain		Pain with insertion of speculum		Post ejaculatory pain
	Pelvic Pain		Pain with finger insertion vaginally		Scrotal pain/numbness
	Burning in perineal area		Pain with tampon use		Penile pain/numbness
	Lower abdominal pain		Vulvar pain/vestibulitis		Other:
	Rectal pain		Other:		

SEXUAL PAIN/DISCOMFORT

1. 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

2. How long have you had pain/discomfort? ____months ____years

3. On a scale of 0-10 (with 10 being the worst possible pain) rate the pain:
   At its worse: ____/10 At best:____/10 Now: ____/10

4. Describe the pain: ☐ Burning ☐ Stinging ☐ Unbearable ☐ Other:

5. Form of birth control used: ☐ Pills ☐ Condoms ☐ Other:

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

6. I have pain/discomfort with the following:

☐ Friction with underwear
☐ Wearing tight pants
☐ Pain with sitting
☐ Partner/self manual stimulation
☐ When I am stressed/anxious pain seems worse
☐ Other:

What treatment have you have for this problem:

Section D:

Is there anything else you feel we should know that would assist your physical therapy treatment?

I have reviewed the above information with the patient:_____

Therapist Signature Date