



FOR INTERNAL USE ONLY  
 DOB: \_\_\_\_\_  
 Last visit: \_\_\_\_\_  
 POC  Yes  No

## PHYSICAL THERAPY WOMEN'S HEALTH SCREENING QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Answering the following questions will help us manage your care better. Please complete this form prior to our appointment.

Please describe your main problem: \_\_\_\_\_

When did your problem begin? \_\_\_\_\_ Is your problem getting:  better  worse  not changing

Do you currently have or have you ever had any of the following? Explain yes responses and include dates.

DATES

DATES

Y N Bladder infections \_\_\_\_\_

Y N Pelvic pain \_\_\_\_\_

Y N Painful intercourse \_\_\_\_\_

Y N Constipation \_\_\_\_\_

Y N Low back pain \_\_\_\_\_

Y N Bone/joint problems \_\_\_\_\_

Y N Abdominal pain \_\_\_\_\_

Y N Sexually transmitted disease \_\_\_\_\_

Y N Menopause \_\_\_\_\_

Y N Other (list) \_\_\_\_\_

Explain yes responses \_\_\_\_\_

	Always	Sometimes	Never
1. Do you have problems with leakage? Urine or stool? (circle one) If no, please skip to question 8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you lose urine when you have a strong urge to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you lose urine with any of the following?			
Coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Active exercise (running, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Do you lose urine with any of the following? (continued)

	Always	Sometimes	Never
Minimal exercise (walking, light housework, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness or increased anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leakage unrelated to any specific cause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please explain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you empty your bladder before you experience the desire to pass urine just so you can stay dry?  Yes  No
5. With leakage, is your clothing  wet a few drops  wet underwear  wet outer clothes  wet floor?
6. Do you use  sanitary pads  tissue paper  diapers for protection? Name brands \_\_\_\_\_
7. How many protective pads do you use per day? \_\_\_\_\_ Are they  damp  wet  saturated at each change?
8. How often do you urinate each day? \_\_\_\_\_ How often do you urinate at night? \_\_\_\_\_
9. Is the volume of urine you usually pass  large  average  small  very small
10. How many glasses of fluid do you drink per day? \_\_\_\_\_ How many are caffeinated? (coffee, tea, soda) \_\_\_\_\_
11. Do you have any bowel or gas control problems? Please explain: \_\_\_\_\_

12. Do you have a feeling of falling out in the pelvic floor area (prolapse)?  Yes  No
13. Do you have pain with intercourse or urination? Describe: \_\_\_\_\_
14. Are you sexually active?  Yes  No Are you trying to get pregnant?  Yes  No
- Number of deliveries: \_\_\_\_\_ Type of deliveries:  Vaginal  Caesarean
- Complications: \_\_\_\_\_

15. Have you ever been instructed on pelvic floor or Kegel exercises?  Yes  No
16. Please describe below any vehicle accidents or personal injuries in which you have been involved. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

17. Have you had any operations?  Yes  No If yes, list type of surgeries and dates \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

18. Do you currently have or have you ever had any of the diseases listed below?
- Y N High blood pressure \_\_\_\_\_
- Y N Heart disease \_\_\_\_\_
- Y N Diabetes mellitus \_\_\_\_\_
- Y N Lung disease \_\_\_\_\_

18 Do you currently have or have you ever had any of the diseases listed below? (continued)

- Y N Stomach disorders (ulcer, etc.) \_\_\_\_\_
- Y N Liver disorders (hepatitis, etc.) \_\_\_\_\_
- Y N HIV positive \_\_\_\_\_
- Y N Glands (thyroid, etc.) \_\_\_\_\_
- Y N Skin disease \_\_\_\_\_
- Y N Cancer \_\_\_\_\_
- Y N Fainting spells \_\_\_\_\_
- Y N Vision problems (not glasses) \_\_\_\_\_
- Y N Hearing problems \_\_\_\_\_
- Y N Multiple sclerosis \_\_\_\_\_
- Y N Stroke \_\_\_\_\_
- Y N Asthma \_\_\_\_\_
- Y N Emphysema/Bronchitis \_\_\_\_\_
- Y N Other \_\_\_\_\_

19. Do you have any allergies?  Yes  No If yes, please list \_\_\_\_\_

20. Do you or any family members have any bleeding tendencies?  Yes  No

21. Are there any diseases or arthritic conditions that run strongly in your family?  Yes  No

If yes, please list \_\_\_\_\_

22. Are you currently taking any medications?  Yes  No If yes, please list \_\_\_\_\_

23. Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

24. What are your goals for treatment? \_\_\_\_\_