

**West Houston Medical Center – Outpatient Rehab 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	<i>Reviewed by &amp; date</i>	

**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		<i>Reviewed by &amp; date</i>		

**ALLERGIES: (List all that apply)**

MEDICATION ALLERGIES	OTHER ALLERGIES	FOOD ALLERGIES
	<input type="checkbox"/> Latex <input type="checkbox"/> Oils/lotion	
	<input type="checkbox"/> Band aid/surgical tape	
		<i>Reviewed by &amp; date</i>

**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			<i>Reviewed by &amp; date:</i>		

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)**

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

<input type="checkbox"/> <u>Voiding Difficulty</u>	<input type="checkbox"/> <u>Pain</u>	<input type="checkbox"/> <u>Bowel History</u>
<input type="checkbox"/> Constipation	<input type="checkbox"/> Bowel Discomfort/pain	<input type="checkbox"/> Falling out of the bowel (rectocele)
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Pain with defecation	<input type="checkbox"/> Pelvic Pressure/heaviness
<input type="checkbox"/> Straining to empty bowels		<input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Trouble feeling bowel fullness		<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Trouble feeling urge to move bowels		<input type="checkbox"/> Childhood bowel problems
<input type="checkbox"/> Can't empty bowels fully		
<b>BOWEL FREQUENCY/URGENCY/CONSTIPATION</b>		
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 _____		
<b>LEAKAGE OF STOOL OR LEAKAGE OF GAS (If you have bowel or gas leakage, please answer the following questions)</b>		
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 _____		
<b>What treatment have you had for this problem:</b>		
<i>Therapist's comments</i>		

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

<input type="checkbox"/>	VAGINAL PAIN	<input type="checkbox"/>	PELVIC DISCOMFORT	<input type="checkbox"/>	GYNECOLOGICAL HISTORY
<input type="checkbox"/>	Painful sex with penetration	<input type="checkbox"/>	Pain in tailbone	<input type="checkbox"/>	Yeast infections
<input type="checkbox"/>	Painful sex with deep thrust	<input type="checkbox"/>	Pain in low back/sacro iliac pain	<input type="checkbox"/>	Candida
<input type="checkbox"/>	Pain hours after sexual penetration	<input type="checkbox"/>	Vulvar Pain/Vestibulitis	<input type="checkbox"/>	Prolapsed uterus
<input type="checkbox"/>	Pain with insertion of speculum	<input type="checkbox"/>	Pelvic Pain	<input type="checkbox"/>	Menopause ____years
<input type="checkbox"/>	Pain with finger insertion into vagina	<input type="checkbox"/>	Burning in perineal area	<input type="checkbox"/>	Menstrual pain/problems
<input type="checkbox"/>	Pain with tampon insertion	<input type="checkbox"/>	Rectal Pain	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	Pain with tampon removal	<input type="checkbox"/>		<input type="checkbox"/>	Adhesions
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	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 <input type="checkbox"/> Sit <input type="checkbox"/> Stand <input type="checkbox"/> Walk <input type="checkbox"/> Other:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	
Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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Therapists comments:

