Stony Brook Medicine

# Outpatient Physical Therapy
# Pelvic Floor Dysfunction History Form

Pt. Label

Date: _____

## SOCIAL HISTORY

DOB: _____ Age: _____ Occupation: _____
Leisure activities/sports played and frequency: _____
Tobacco Use: packs per day: Present ____ Past ____ Alcohol Consumption: ___ drinks per day/week/month (circle one)

## HISTORY OF PRESENT CONDITION/SYMPTOMS

What problem brings you to physical therapy today? _____
When did this problem begin? (Specific date if known) _____
Did this problem begin gradually or suddenly? Please describe: _____
_____

Have you had surgery for this condition? Yes ☐ No ☐
If yes, please indicate the date: _____ Type of surgery: _____
Facility where you had surgery: _____ Name of surgeon: _____

Since this problem began have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same
Please Describe: _____

How much have your symptoms interfered with your usual daily activities? (Include inside and outside the home and at work.) ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Perceived severity of condition: 0-10 (10 being worst): _____/10

How much have your symptoms interfered with your recreational and/or leisure activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

If you have pain: Please grade your pain level:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At rest: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | No Pain | | | | | | | | | | Most Pain |
| With activity: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | No Pain | | | | | | | | | | Most Pain |

Where is your pain? _____
Describe your pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Burning ☐ Tingling ☐ Numbness
Other: _____
How often do you have pain?
☐ Constant (76-100% of the time) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (less than 25%)

## FEMALES ONLY: OB/GYN History

Date of first period: _____ Menopausal? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No If yes, do you have (please circle): Discomfort Pressure Change in Feeling
Bowels: Circle any that apply: Loose Normal Constipated Incontinent

Do you have (Check if YES): ☐ Dysmenorrhea (painful periods) ☐ Pelvic Inflammatory Disease ☐ Endometriosis
☐ Fibroids ☐ Cysts ☐ Back/Leg Pain ☐ Dyspareunia (painful intercourse) ☐ Prolapse ☐ UTI ☐ Pelvic Pain
☐ Hemorrhoids ☐ Menses Late ☐ GI Dysfunction

Pt. Label

Date: _____

| **Birth History:** | Date | Weight | Delivery Type | Episiotomy/Lac | Other |
|---|---|---|---|---|---|
| G P | | | | | |
| G P | | | | | |
| G P | | | | | |
| G P | | | | | |

G = Gravida (pregnancy) P = Parity (living birth)

**MALES AND FEMALES: Urogynecologic Symptoms**

UTI ___ Hematuria ___ Hesitancy ___ Dysuria ___ Prolapse ___ Dribbling after urination ___
Urge Sensation Present ___ Empty Completely ___ Falling out feeling ___ Vaginal dryness ___
Leaks per day _____ Sm/Md/Lg Caused by: _____
Voiding frequency _____ Nocturia _____ Nocturnal Enuresis _____
Amount of warning before urination: _____ Fluid intake amount: _____ oz. per day
Dietary changes: _____

What diagnostic tests/procedures have you undergone for this condition? (i.e. MRI, x-ray, CT scan) Please list dates and results: _____
Have you received treatment for this condition in the past? ☐ Yes ☐ No
If yes, please indicate type and date of treatment: ☐PT ☐ OT ☐ MD ☐ Chiropractor ☐ Other: _____
Dates of treatment: _____
Are you taking any medications for this condition? _____ If yes, please list: _____
_____
Please list any other medications you are taking: _____
_____

**PAST MEDICAL HISTORY**

| PAST | PRESENT | CONDITION | PAST | PRESENT | CONDITION |
|---|---|---|---|---|---|
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Heart Condition |
| ☐ | ☐ | Stroke | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Seizure Disorder | ☐ | ☐ | Arthritis |
| ☐ | ☐ | HIV | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Hepatitis | ☐ | ☐ | Migraines/Headache |
| ☐ | ☐ | Lung Disease | ☐ | ☐ | Cancer; Location _____ |
| ☐ | ☐ | Pregnancy | Are you presently pregnant? ☐ Yes ☐ No ☐ N/A | | |

List any allergies: _____
Other medical conditions not noted above: _____
What do you hope to accomplish by attending physical therapy? _____

Patient Signature: _____ Date: _____

For therapist use only:
_____
_____
_____
Above report reviewed for accuracy with patient.

Therapist Signature/ID: _____ Date: _____ Time: _____