Northwestern Medicine Palos Hospital
Physical Medicine and Rehabilitation

Pelvic Health Questionnaire

Thank you for filling out this questionnaire. It will assist your doctor/therapist in planning safe and effective treatment.

Name: _____ **Preferred Name:**_____ **Date of Birth:** ____/____/_____
Preferred Pronouns (please circle): she/her he/him them/their **Height:** _____ **Weight:** _____ **Age:** _____
Current Gender Identity: _____ **Gender Assigned at Birth:** _____
What is your preferred language to discuss healthcare decisions? ☐ English ☐ Other: _____
Referring Physician: _____ **Next appointment date with Physician:** _____
How did you hear about our services?
☐ Physician ☐ Website ☐ Family/Friend ☐ Newspaper/Ad ☐ Fitness Center ☐ Social Media
☐ Community Program (specify) _____ ☐ Other: _____

Have you received any Home Health Services in the past 30 days? ☐ Yes ☐ No If yes, explain: _____
How often do you have problems learning about your medical condition because of difficulty understanding health information?
☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never

CURRENT CONDITION & HISTORY

Describe the current issue or recent surgery that brings you here today: _____
_____
Date of Surgery/Onset of issue: _____
Are your symptoms: ☐ Improving ☐ Staying the Same ☐ Getting Worse

Urinary Function:

How many times do you urinate in a day (waking hours) _____ at night _____
Do you have urinary leakage with any of the following:
☐ Standing ☐ Sitting ☐ Rising from a chair ☐ Coughing ☐Sneezing ☐ Laughing ☐ Lying down ☐ Getting up from lying
☐ Hearing running water ☐ Putting key in door ☐ Post-urination/defecation ☐ Post intercourse/penetration
Do you experience urinary urgency? ☐ Yes ☐ No Do you experience difficulty emptying fully? ☐ Yes ☐ No
Do you wear protective garments due to leaking? ☐ Yes ☐ No If yes, how many per day? _____
Do you completely sit on the toilet seat to urinate/defecate, including public restrooms? ☐ Yes ☐ No
How many cups (8oz) of fluid do you have a day? _____
What types of fluid other than water do you intake? ☐ soda ☐ diet soda ☐ coffee ☐ tea ☐ juice ☐ other_____

Bowel Function:

How many times a day/week do you have a bowel movement? _____
What is the average consistency of your stool? ☐ Hard/lumpy ☐ Soft, but formed ☐ Loose/pieces ☐ Watery
Do you strain to have a bowel movement? ☐ Yes ☐ No
Do you experience fecal urgency? ☐ Yes ☐ No Do you experience unwanted passage of gas? ☐ Yes ☐ No
Do you take medication or supplements to assist with regularity? ☐ Yes ☐ No If yes, describe _____

Sexual Function:

Are you sexually active? ☐ Yes ☐ No ☐ Prefer not to say Do you have pain with stimulation or intercourse? ☐ Yes ☐ No
Do you have difficulty or inability achieving orgasm? ☐ Yes ☐ No Do you or have you ever had pelvic pain? ☐ Yes ☐ No
Do you experience dribbling post ejaculation? ☐ Yes ☐ No ☐ Not Applicable
Do you have difficulty achieving or maintaining erection? ☐ Yes ☐ No ☐ Not Applicable

Obstetric History:

Are you currently pregnant? ☐ Yes ☐ No
Do you have history of pregnancies? ☐ Yes ☐ No If yes, how many _____ Mode of delivery _____

General History (check all that apply):

☐ Cesarean section	☐ Hysterectomy	☐ Oophorectomy	☐ Tubal ligation	☐ Bladder sling/repair
☐ Vaginal repair	☐ Prolapse	☐ Polyps/cysts/fibroids	☐ Endometriosis	☐ Trauma/sexual abuse
☐ Hemorrhoids	☐ Lymphedema	☐ Enlarged prostate	☐ Prostatitis	☐ Prostate cancer
☐ Prostatectomy	☐ Hydrocele	☐ Urinary Tract Infection	☐ Irritable Bowel Syndrome (IBS)	
☐ Arthritis	☐ Rheumatoid arthritis	☐ Seizures	☐ Thyroid problems	☐ Anxiety
☐ Nerve damage	☐ Dizziness/blackouts	☐ Heart attack	☐ Depression	☐ Lung disease
☐ Kidney disease	☐ Heart disease	☐ Diabetes	☐ Gout	☐ High blood pressure
☐ Stomach ulcers	☐ Headaches	☐ Vision problems	☐ COPD	☐ Hearing problems
☐ Stroke/TIA	☐ Osteoporosis	☐ Fibromyalgia	☐ Cancer (please describe) _____	
☐ Surgery (please describe) _____			☐ Other _____	

Have you had any testing? ☐ X-rays ☐ MRI ☐ CT Scan ☐ Urinalysis ☐ Pap smear ☐ Colonoscopy ☐ Other _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No Treatment: _____

What is your goal as a result of treatment? _____

Do you have a Pacemaker? ☐ Yes ☐ No **Are you on blood thinners?** ☐ Yes ☐ No **Do you have any metal implants?** ☐ Yes ☐ No

Unexplained weight loss or gain? ☐ Yes ☐ No **Fever, chills or night sweats?** ☐ Yes ☐ No

Allergies: ☐ Iodine ☐ To Bees ☐ To tape ☐ Latex ☐ Other _____

If you have pain, what is your pain level? (0 = No Pain, 10 = Extreme Pain)

At Best:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10

Symptom Description: ☐ Numbness ☐ Pins & Needles ☐ Burning ☐ Sharp ☐ Dull ☐ Constant ☐ Come and Go ☐ Other _____

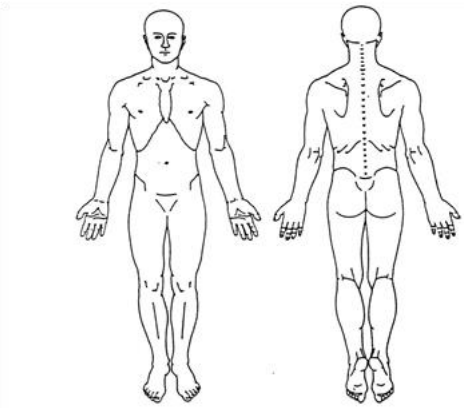
Is pain worse at a certain time of day? ☐ Yes ☐ No

☐ Morning ☐ Night ☐ Other _____

Does your pain progress as the day goes along? ☐ Yes ☐ No

Do you wake due to the pain? ☐ Yes ☐ No

Mark the location of your pain with an "X"



AT RISK SCREENING

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _____ If yes, was there an injury involved? ☐ Yes ☐ No

Do you feel unsteady when standing or walking? ☐ Yes ☐ No Do you have worries about falling? ☐ Yes ☐ No

What do you do for physical activity? _____

In the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things: ☐ Not at all ☐ Several Days ☐ More than ½ the days ☐ Nearly every Day

Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several Days ☐ More than ½ the days ☐ Nearly every Day

Would you like help with how you're feeling? ☐ Yes – today ☐ Yes, but not today ☐ No

Do you take medications or drugs (including nonprescription drugs)? ☐ Yes ☐ No If yes, please list below or attach list.

NAME OF MEDICATION/DRUG	FOR WHAT?	NAME OF MEDICATION/DRUG	FOR WHAT?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient/Authorized Representative Signature _____ **Relationship to Patient** _____