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? __________

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
- Polypys/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

**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

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**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?**
- Morning
- Night
- Other

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

**Do you wake due to the pain?**
- Yes
- No

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**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

**Do you take medications or drugs (including nonprescription drugs)?**
- Yes
- No

**If yes, please list below or attach list.**

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<thead>
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**Patient/Authorized Representative Signature**

**Relationship to Patient**