Date________________

Name____ Date of Birth___________

Brief description of diagnosis/Reason for referral:

____

____

Date symptoms first began____

Level of discomfort/pain (0-10, 0 represents no pain)________________________

What makes symptoms worse?____

What makes symptoms better?____

Previous surgeries with dates (years)_______________________________________

____

# of Pregnancies_____ # of births______ # of Vaginal deliveries_____

# of Caesareans_____ # of Episiotomies_____ # of Vaginal tears and grade______

Current Medications/Reason for taking____________________________________

____

____

Allergies? (drug/environmental/food)______________________________________

How physically active are you?

______ Very Active (exercise 5-7 days/week)

______ Active (exercise 3-5 days/week)

______ Somewhat Active (exercise 1-2 days/week)

______ Not Active (I park in the closest parking spot)

Average fluid intake/day (and types of drinks)______________________________

Sleep habits (trouble falling asleep, staying asleep)__________________________

Dr. Lauren Crigler, DPT

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Medical History: Please check all that apply

____High Blood Pressure
____Heart Disease
____Osteoporosis
____Arthritis
____Thyroid Condition
____Diabetes
____Breathing Problems
____Cancer
____Currently Pregnant?
____Circulation Disease

Infectious Disease (HIV, Hepatitis, etc.)__________________________________

Recurrent muscle joint pain problems____________________________________

Gynecological History: Please indicate all that apply

Have your menstrual periods stopped? Yes___ No___

On hormone replacement replacement therapy? Yes___ No___

Do/did you have pain with your menstrual periods? Yes___ No____

Do/did you have pain with intercourse? Yes___ No___

Endometriosis___ Prolapse___ Cysts____

Pelvic Inflammatory Disease___ Fibroids___ Pelvic Pain___

Other (include GYN surgeries)____

Bowel Habits: Do/did you experience frequent constipation? Yes___ No____

Do/did you frequently take laxatives? Yes___ No___

Do/did you have incontinence (leakage) episodes? Yes____ No___

How often do you have bowel movements?________________________________

Urinary Incontinence Symptoms: How many accidents/day (small/large?)______

Do you wear protection?_____ # of changes/day?_____# of times urinate/day____

Do you leak when you have a strong urge to void?__________________________

Do you leak w/coughing__ Laughing__ Sneezing__ Lifting__ Bending__ Sex___

Are you able to completely empty your bladder?______ Pain with urinating?____

Do you strain to empty?_________ Any trouble starting your stream?__________

Please list any other symptoms that may be of concern:

____

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