ALPINE

Pelvic Floor Health History

Please fill out as completely as possible. It will assist your therapist in developing the most appropriate treatment.

Name:_____ Age: _____ Height/ Weight_____ /_____

Please describe your main problem_____

_____

When did it begin? _____ Is it: _____ getting better _____ getting worse _____ staying the same

Please describe activities or things you cannot do because of your problem _____

_____

Are you sexually active? Yes / No Are you currently pregnant/attempting pregnancy? Yes / No

Do you have pain or problems with sexual activity?_____

_____

_____

FEMALES: Gynecological/ Obstetric History:

Number of: Pregnancies _____ Miscarriages _____ Vaginal deliveries _____ C-Sections _____

Episiotomies: Yes / No Did you experience tearing or need stiches? Yes / No

Birthdays and weight of babies:_____

_____

Any Problems (physical or other) following deliveries? _____

_____

Any history or current complaints of pelvic heaviness, fibroids, cysts, endometriosis?_____

_____

Please list all pelvic and abdominal surgeries_____

_____

Date of last pelvic exam: _____ Date of last urinalysis _____

Menstrual History (ie. Frequency, pain, flow)_____

_____

MALES:

Have you had a prostate exam in the last 12 months? YES / NO

Do you have testicular pain? YES / NO

Do you have erectile dysfunction? YES / NO

Do you have prostate disease? YES / NO

If yes, please describe_____

(PLEASE CONTINUE FORM ON OPPOSITE SIDE)

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ALL PATIENTS: (if applicable)

How often do you leak urine? (pick one)

☐ Never[0] ☐ Once a week or less[1] ☐ Two to three times a week[2] ☐ Once a day[3] ☐ Several times a day[4] ☐ All the time[5]

How much urine do you usually leak (whether you are wearing protection or not)?

☐ None[0] ☐ A small amount[2] ☐ A moderate amount[4] ☐ A large amount[6]

Overall, how much does leaking urine interfere with your everyday life? (0 not at all, 10 a great deal)

1 2 3 4 5 6 7 8 9 10

When do you leak? (Please check all that apply to you)

☐ Never ☐ Just before I can get to the toilet ☐ When I cough or sneeze ☐ When I am asleep
☐ After I have finished urinating and am dressing ☐ No obvious reason ☐ When I am physically active/exercising

Incontinence History: Please select the best answer for each question if applicable

1) Protection Used?

☐ No Protection ☐ Pantyshield ☐ Mini-pad ☐ Maxi-pad ☐ Diaper

2) How long can you delay the need to urinate?

☐ 1+ hours ☐ ½ hour ☐ 15 minutes ☐ 1-2 minutes ☐ not at all

3) Frequency of Urination (daytime)

☐ 0 times a day ☐ 1-4 times a day ☐ 5-8 times a day ☐ 9-12 times a day ☐ 13+ times a day

4) Frequency of Urination (nighttime)

☐ 0 times a night ☐ 1 time a night ☐ 2 times a night ☐ 3 times a night ☐ 4 times a night

5) Daily Fluid intake (includes water and other beverages, 8 oz/glass)

☐ 9+ glasses (72 oz) ☐ 6-8 glasses (48-64 oz) ☐ 3-5 glasses (24-40 oz) ☐ 1-2 glasses (8-16 oz)
How many caffeinated glasses? _____

6) Frequency of Bowel movements

☐ 2 times a day ☐ 1 time a day ☐ Every other day ☐ Once every 4-7 days ☐ Weekly

Do you experience, and if so, how much are you bothered by your main problem:	0 = Not at all	1 = Slightly	2 = Moderately	3 = Greatly
Frequent urination/ defecation?				
Leakage related to the feeling of urgency?				
Do you strain to pass urine or have a bowel movement?				
Difficulty emptying completely				
Pain or discomfort in the lower abdominal region or genital area?				
A feeling of bulging or protrusion in the genital region?				
Bulging or protrusion you can see/ feel in the genital region?				
Have pain with bladder/bowel movements?				