Pelvic Floor Physical Therapy
Initial Evaluation

UROLOGY SAN ANTONIO

SALUTATION

Title (Mr., Mrs., Miss, Ms. Dr.,_____) First and Last Name:_____

Date of Birth_____/_____/_____ Age_____ Gender (Male/Female)

REFERRING PHYSICIAN

Doctor which referred you to our clinic:_____

When is your next doctor's appointment for follow-up of this condition? _____/_____/_____

CURRENT SYMPTOM ONSET

How recent did the symptoms start or become worse? _____ (days, weeks, months, years) ago

How did the symptoms appear? (suddenly, gradually, insidiously)

How long have the symptoms persisted for? _____ (days, weeks, months, years)

What was the cause of the symptoms? (i.e. car accident, fall, surgery, other)_____

Have the symptoms (worsened, improved, remained the same)?

MEDICATION(S) – taken for CURRENT symptoms:

First medication_____

Taken (_____ times/day, every ____ hrs. as needed)

Second medication_____

Taken (_____ times/day, every ____ hrs. as needed)

Third medication_____

Taken (_____ times/day, every ____ hrs. as needed)

_____

All OTHER medications taken:

_____

_____

_____

_____

_____

CURRENT PAIN

What would you rate your pain level NOW on a scale of 0-10,
With 0 being without pain and 10 being the worst? ____/10

What is your pain rated in the morning? _____/10
What is your pain rated in the afternoon?_____/10
What is your pain rated in the evening?_____/10

Visual Analog Pain Scale (VAS)

0=no pain
1-2 = mild pain, can be ignored
3-4 = moderate pain, interferes with tasks
5-6 = interferes with concentration
7-8 = severe pain, interferes with basic needs
9-10 = worst pain possible, needing to go to ER

RELATED SURGERIES – *Please list surgeries which may relate to the condition we will be treating.*

Most recent surgery_____ Date of Surgery _____/_____/_____
Location of incision_____ Incision (healed / not healed)
Physician_____ Recovery (poor, satisfactory, full)
Complications or limitations from surgery_____

Other surgery_____ Date of Surgery _____/_____/_____
Location of incision_____ Incision (healed / not healed)

Other surgery_____ Date of Surgery _____/_____/_____
Location of incision_____ Incision (healed / not healed)

PRECAUTIONS

Have you been given any precautions or limitations by your doctor? (yes / no)

_____

How long is the precautionary period to last? _____ (days, weeks, months, years)

Pelvic Floor Physical Therapy
Medical History

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History of	You	Family Member
Cancer	❑	❑
Diabetes	❑	❑
High Blood Pressure	❑	❑
Heart Disease	❑	❑
Angine/Chest Pain	❑	❑
Stroke	❑	❑
Osteoporosis	❑	❑
Osteoarthritis	❑	❑
Rheumatoid Arthritis	❑	❑

Do you presently smoke? Y / N
_____ Packs per day for _____ years
Last tobacco use:_____
Do you drink alcoholic beverages? Y/ N
_____Drinks per day/week

Do you have a history of

- ❑ Allergies / Asthma
- ❑ Headaches
- ❑ Bronchitis
- ❑ Kidney Disease
- ❑ Rheumatic Fever
- ❑ Ulcers
- ❑ Sexually Transmitted Disease
- ❑ Positive Tuberculosis Testing
- ❑ Living with someone who had Tuberculosis
- ❑ Hearing impairment
- ❑ Vision impairment
- ❑ Speech impairment
- ❑ Communication impairment

In the past 3 months have you had or do you experience

- ❑ A change in your health
- ❑ Loss of strength or energy
- ❑ Nausea / Vomiting
- ❑ Fevers / Chills / Sweats
- ❑ Change in bowel / bladder function
- ❑ Menstrual irregularities
- ❑ Shortness of breath
- ❑ Dizziness
- ❑ Upper Respiratory infection
- ❑ Urinary Tract infection
- ❑ Been bother by feeling down, depressed, or hopeless
- ❑ Been bothered by little interest or pleasure in doing things

Do you have difficulty...

- ❑ Driving
- ❑ Lifting
- ❑ Bending at the waist
- ❑ Walking
- ❑ Running
- ❑ Playing Sports
- ❑ Standing
- ❑ Getting up from a chair
- ❑ Getting regular exercise

Are your symptoms...

- ❑ Getting worse
- ❑ The same
- ❑ Improving

How are you able to sleep at night?

- ❑ Fine
- ❑ Moderate difficulty
- ❑ Only with medication

Are you currently...

- ❑ Pregnant
- ❑ Under stress

Medical Tests Performed

X-Ray ____/____/_____
EMG ____/____/_____
MRI ____/____/_____
CAT Scan ____/____/_____
Mylogram ____/____/_____
Ultrasound ____/____/_____

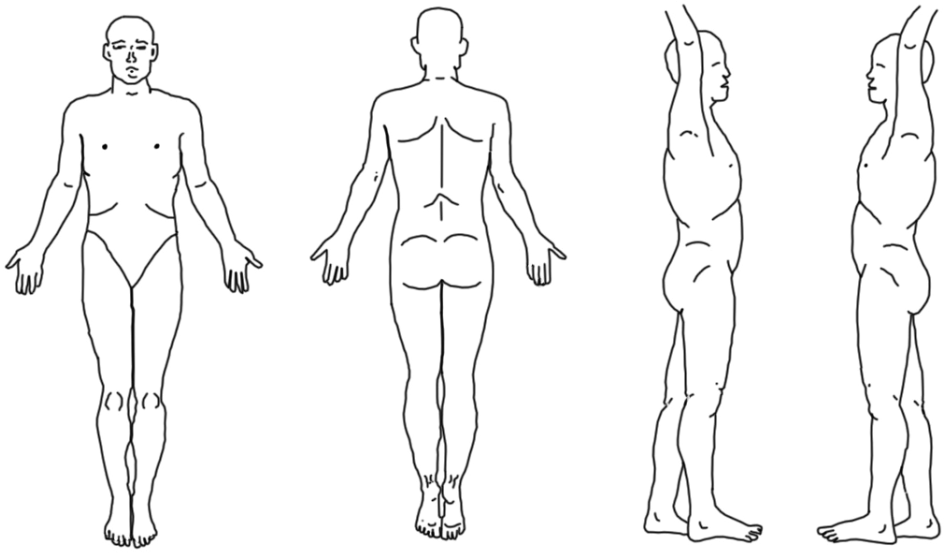
Where were these tests performed?

_____

_____

Date of last physical examination:
____/____/_____

Please indicate each area you have pain or other symptoms



Pelvic Floor Physical Therapy
Questionnaire

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History

Do you have a history of sexual abuse or trauma	Y	N	**Do you have pain with:**		
			Sexual Intercourse	Y	N
Do you have frequent urinary tract infections	Y	N	Back, leg, groin, abdominal pain	Y	N

Bladder Symptoms

Do you lose urine when you:

Cough/sneeze/laugh	Y	N	Lift/exercise/dance/jump	Y	N
On the way to the bathroom	Y	N	Hear running water	Y	N

Do You:

Have a strong urge to urinate	Y	N	Wet the bed	Y	N
Have burning/pain with urination	Y	N	Urinate more than 7 times per day	Y	N
Strain to empty your bladder	Y	N	Feel unable to empty bladder fully	Y	N
Have a falling out feeling	Y	N	Have pain with a full bladder	Y	N
Have a strong stream	Y	N	Does your stream start and stop	Y	N
Have an urgency of urination (a strong urge to urinate)	Y	N	Have difficulty starting a stream of urine	Y	N

Other_____

Bowel Symptoms

Do You:

Strain to have a bowel movement	Y	N	Leak/stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives/enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N	Have a very strong urge to move your bowels	Y	N

How often do you move your bowels: _____ per day/week

Most common stool consistency: _____ liquid _____ soft _____ firm _____ pellets _____ other

Test Results

Urodynamics Test	Y	N	Results:_____
Cystoscope	Y	N	Results:_____
Urine Test	Y	N	Results:_____
Bowel test	Y	N	Results:_____

Males Only

Do you have pain with ejaculation	Y	N	Do you experience dribbling after urination	Y	N

Females Only

Number of pregnancies: _____			Number of vaginal deliveries: _____		
Birth weight of largest baby: _____			Number of cesarean deliveries: _____		
Number of episiotomies: _____			Date of last pap smear: _____		
Did you have any trouble healing after delivery	Y	N	Do you have pain with tampon use	Y	N
Are you having regular periods/menstrual cycles	Y	N	Do you have pain with pelvic exam	Y	N