

THE WOMEN'S HEALTH PROGRAM AT ALEXANDER SPRING REHAB
Women's Health Questionnaire

Name: _____ Date of Birth: _____

Date: _____

1. Please describe the problem for which you have been referred for physical therapy:

2. Urinary Incontinence History: Please fill out the following ONLY if you are having problems with urinary incontinence. Otherwise proceed to #3.

When did your problem with incontinence begin? _____

Previous Treatment for Incontinence:

Yes / No Have you done exercises to control urine loss?
Yes / No Has your doctor prescribed any medication to treat urine loss?
Yes / No Have you had any surgical procedures to treat urine loss?

When does loss of urine occur? (please circle as appropriate): When you stand up?

coughing? laughing? sneezing? lifting objects? walking? running?

exercise? with "key-in-lock"? getting to toilet/while removing clothes?

with exposure to water? on the way to the bathroom? while sleeping?

when you have a strong urge to urinate? ("get out of my way, I've got to go!")

Do You:

Yes / No Experience an urge to urinate when you hear, see or feel water?
Yes / No Have difficulty initiating a urine stream?
Yes / No Have difficulty stopping your stream?
Yes / No Have pain with urination?
Yes / No Have burning with urination?
Yes / No Have to strain to empty your bladder?
Yes / No Dribble urine when you are urinating?
Yes / No Dribble after you empty your bladder?
Yes / No When you stand after voiding, do you feel like you have to sit back down to finish?

Frequency of Incontinence: How often are you incontinent each: day? ____ night? ____

Voiding Frequency: How many times do you void each day? ____ Each night? ____

What type of protective device do you use? (check all that apply):

Panty liner ____ Sanitary pad (mini) ____ Sanitary pad (maxi) ____
Incontinence pad: Poise ____ Attends ____ Serenity ____ Incontinence Brief ____
Other: _____

of pads used each day: ____ Do you change the pad each time it is wet? Yes / No

Impairment Rating: What are your feelings about your urinary incontinence on a scale of 0 to 10?

No impairment - 0 1 2 3 4 5 6 7 8 9 10 - Severe impairment

Please see reverse

2. Urinary Incontinence History (continued):

Functional Limitations: Have you had to restrict your activities due to urinary incontinence? Yes / No If yes, explain: _____

Have you had changes in intimate relationships/sexual functioning due to urinary incontinence? Yes / No _____

Bowel habits:

How often do you have a bowel movement? _____

Are you ever constipated? _____ How do you resolve this? _____

Do you experience diarrhea? _____

Do you use laxatives? _____ How often per week? _____

Do you use enemas? _____ How often per week? _____

Do you include fiber in your diet (fruit, vegetables, bran, etc.)? _____

Food/Fluid Intake:

Do you consume sugar, sweets? _____ Do you use artificial sweeteners? _____

of cups of fluid per day _____ Of those, how many are: Caffeinated? _____

Carbonated? _____ High in acid? (tomato, orange or cranberry juice)? _____

Alcohol consumption: How much/how frequent? _____

Do you restrict fluids because of your incontinence? Yes / No

3. Patient's Goals: _____

4. General Medical History: Please check all of the following that apply to:

	You	Parent	Sibling	Grandparent
Asthma/emphysema/COPD	___	___	___	___
Heart attack/heart problems	___	___	___	___
Stroke	___	___	___	___
High blood pressure	___	___	___	___
Diabetes (blood sugar problem)	___	___	___	___
Arthritis	___	___	___	___
Seizure disorder	___	___	___	___
Cancer	___	___	___	___
Circulatory problems	___	___	___	___
Osteoporosis	___	___	___	___
Cholesterol problem	___	___	___	___
Problems with your eyesight (other than corrective lenses)	___	___	___	___
Dizziness, fainting spells	___	___	___	___
Hearing aid	___	___	___	___
Metal implants	___	___	___	___
Radioactive implants	___	___	___	___
Pacemaker or implanted defibrillator	___	___	___	___
Thyroid problem	___	___	___	___
Fractures	___	___	___	___
Low back pain or hip pain	___	___	___	___
Other: _____	___	___	___	___

5. Obstetrical/Gynecological History:

- | | |
|-------------------------------------|------------------------------|
| ___ Dysmenorrhea | ___ Vulvodynia |
| ___ Menopause. Age at menopause ___ | ___ Hemorrhoids |
| ___ Fibroid | ___ Urinary tract infections |
| ___ Cysts | ___ Endometriosis |
| ___ Pelvic inflammatory disease | ___ Crohn's disease |
| ___ Interstitial cystitis | ___ Irritable bowel syndrome |

Continued:

5. Obstetrical/Gynecological History - Continued:

___ Any pelvic, abdominal or vaginal surgeries? Please list: _____

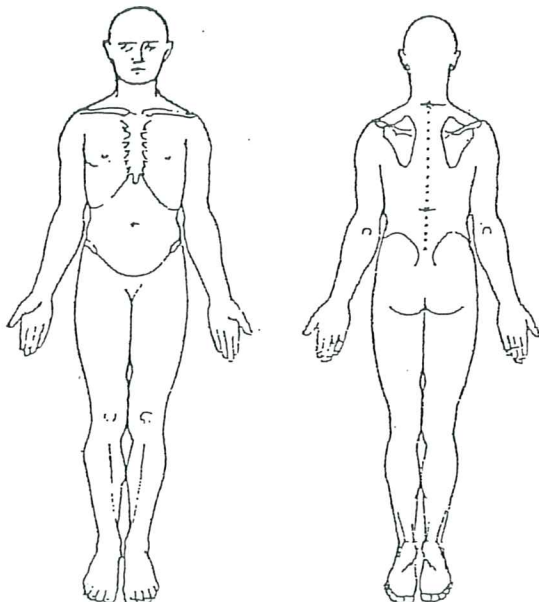
___ Surgery other than above? Please list: _____

Is there a possibility that you are pregnant? Yes ___; No ___

Deliveries:

Date	Delivery Weight	Trauma (including episiotomy)

6. Pain: Indicate your symptoms on the body diagram, using:
xxx for pain symptoms; ooo for numbness symptoms; /// for tingling:



Please rate your pain on a scale of 0-10, with 0 being no pain, and 10 being the worst pain imaginable (such that you would go to the emergency room):

At rest: ___/10; with activity ___/10.

Pain is worse at what time of day? Early a.m. ___; Late a.m. ___; Early p.m. ___; Late p.m. ___; Nighttime ___.

7. Medications: Please list all prescription and over-the-counter medications and vitamin and herbal supplements you are currently taking, including dosages, number of times per day, including hormone replacement therapy (prescription & non-prescription): _____

8. Do you have any allergies, including latex or tape products? Please list: _____

9. Do you live alone? Yes ____; No ____

10. What is your occupation/main job duties? _____

11. Do you do any recreational activities? Yes ____; No ____ . If so, what kind?

Do you smoke or chew tobacco? ____ # of packs per day ____ If no, do you have a prior smoking history? (how much and how long): _____

Do you drink alcohol? ____ # of drinks per week ____

12. Clinical Tests: Within the past year, have you had any of the following tests? Check all that apply.

- | | |
|---------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Urodynamics | <input type="checkbox"/> Echocardiogram |
| <input type="checkbox"/> Post-void residual | <input type="checkbox"/> EEG (electroencephalogram) |
| <input type="checkbox"/> Urine test | <input type="checkbox"/> EKG (electrocardiogram) |
| <input type="checkbox"/> Pap smear | <input type="checkbox"/> EMG (electromyogram) |
| <input type="checkbox"/> Stool test | <input type="checkbox"/> Mammogram |
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Myelogram |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> NCV (nerve conduction velocity study) |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> Bone scan | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Stress test (e.g. treadmill, bicycle) |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Doppler ultrasound | <input type="checkbox"/> DEXA Scan |
| <input type="checkbox"/> Other: _____ | |

13. Functional Status/Activity Level (check all that apply)

- Difficulty with locomotion/movement
- Bed mobility
- Transfers (i.e. moving from bed to chair, from bed to commode, getting on/off the toilet).
- Gait (walking): On level: ____ On stairs: ____ On ramps: ____ On uneven terrain: ____
- Do you use a: Cane ____ Walker ____ Wheelchair ____ Lean on furniture for balance ____
- Sleep disturbance. If yes, describe: _____