

Outpatient Physical Therapy Pelvic Floor Dysfunction History Form

Pt. Label	

								Date:						
SOCIAL HIST	TORY													
					•									
DOB:			Age: _		Occu	pation:								
Leisure activi											day/week/mon	+b (sirsle one)		
TODACCO OSE.	. раскѕ ре	r uay. F	resent_	Pa	st	AICOHO	Consul	iiptioii	um	ks per c	iay/week/iiioii	tii (tirtie olie)		
HISTORY OF	PRESEN	T CON	DITION	/SYMP	TOMS									
What proble	m brings v	ou to r	hysical t	:herapy	today?									
Have you had														
Facility where	e you had	surger	y:					Name	e of sur	geon: _				
Since this pro Please Descri	_			•		•			□ S ¹	tayed tl	ne same			
How much hawork.) □ No Perceived seventher How much ha □ Not at all	ot at all verity of co ave your s	☐ A I onditio ympto	ittle bit n: 0-10 (ms interf	□ M 10 bein fered w	oderate ng worst) rith your	ly QQ): recreat	uite a bi _/10 ional and	t □ Ext	tremely	/	nd outside the	home and at		
If you have p						aite a bi		ceremery						
At rest:	0	1	2	3	4	5	6	7	8	9	10			
	No Pain	-	_	J	•	J	Ü	•	Ü	J	Most Pain			
With activity:		1	2	3	4	5	6	7	8	9	10			
•	No Pain										Most Pain			
Where is you														
Describe you Other:	•		•			-	hooting	☐ Burn	ing 🗆	l Tinglin	g 🗆 Numbne	SS		
How often do □ Constant (-	•		⊒ Frequ	uent (51-	-75%)	□ Occa	sional (26	5-50%)	☐ In	termittent (less	s than 25%)		
				•	•	,		`	•			•		
FEMALES ON			-		15									
Date of first p									·:	: D		aa in Faalina		
									uscomi	ort P	ressure Chan	ige in Feeling		
Bowels: Circl	e any that	appiy:	Loose	NOT	iliai CC	ภารแหล่แ	a IIIC	onunent						
Do vou have	(Check if \	/F\$\·	□ Dv/	smenor	rhea Ing	inful na	rindsl	□ Pelvic	Inflam	mator	Disease 🗆 E	ndometriosis		
											se 🗆 UTI 🛭			
□ Hemorrho			_				 11	, , , , , , , , , , , , , , , , , , , ,	-, –					

Date:													
Birth I	listory:	Date	Weight	Deliver	у Туре		Episiotomy/Lac	Other					
G	Р												
G	Р												
G	Р												
G	Р												
G = Gr	G = Gravida (pregnancy) P = Parity (living birth)												
MALES AND FEMALES: Urogynecologic Symptoms													
UTI Hematuria Hesitancy Dysuria Prolapse Dribbling after urination													
Urge Sensation Present Empty Completely Falling out feeling Vaginal dryness													
	Voiding frequency Nocturia Nocturnal Enuresis Amount of warning before urination: Fluid intake amount: oz. per day												
							02. p	er day					
Dietary changes:													
Have y	ou received	treatment for t	his condition in	the past?	☐ Yes	□ No							
If yes,	please indica	ite type and dat	e of treatment:	□PT □ OT	\square MD	☐ Chiro	practor 🗖 Othe	r:					
Dates	of treatment	:											
Are yo	u taking any	medications fo	r this condition?	? If yes,	please l	ist:							
Please	list any othe	r medications y	ou are taking: _										
DAST	MEDICAL H	ISTORV											
PAST		CONDITIO	N		PAST	PRESEN	T CONDIT	ION					
		High Bloo	d Pressure				Heart C	ondition					
		Stroke						Diabetes					
		Seizure Di	sorder					Arthritis					
		HIV	301461					Kidney Disease					
	_					_	•	•					
		Hepatitis						Migraines/Headache					
		•	Lung Disease										
		Pregnancy					,	☐ Yes ☐ No	⊔ N/A				
		ditions not note											
What do you hope to accomplish by attending physical therapy?													
Patient Signature:							Date:						
For th	erapist use o												
Above report reviewed for accuracy with patient.													
Т	herapist Sign	nature/ID:			D	ate:	Time:						

Pt. Label