MARSHALL
MEDICAL CENTER

It's about you

Outpatient Rehabilitation
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Patient History Form

Please fill in the following questionnaire to the best of your ability. The therapists will review your answers with you at your appointment.

1. Please describe the problems that brought you to this appointment: _____
   _____
   _____
   _____
2. When did your problem first start? _____
3. Do you have a history of similar problems?_____

4. Was your problem related to a specific incident? If so, please describe. _____
   _____
5. Are your symptoms:
   ____ staying the same ____ getting worse _____ getting better?

   Please describe:_____

6. Occupation:_____**Circle all that apply**: Full-time/Part- time/Volunteer/Retired/Unemployed/Leave/Disability
7. How has this problem impacted your daily social/physical/work activities?
   _____

8. Amount/type of weekly exercise_____
9. Current level of stress (**circle one**): Low Medium High
   Currently in behavioral health therapy? Y/N.
10. How severe is your problem on a **1-10 scale** (1 = no problem, 10 = the worst) _____
11. How would you rate your pain on a **1-10 scale** (1 = no problem and 10 = bad enough for an ER trip).? _____

12. How would you describe your pain and where is it located? _____

13. Do you have pain or increased difficulty with any activities: **Check or circle all that apply.**

____Prolonged sitting greater than ____ minutes
____Prolonged standing greater than ____ minutes
____Walking greater than ____ minutes

____Turning in bed
____Standing up from a chair
____Getting on and off the floor

____Light activity (laundry/cleaning/cooking)
____Heavy activity/exercise (running, jumping, dancing, lifting weights)
____Sexual intercourse/activity

____ With cough/sneeze/straining
____ With laughing/shouting
____ With bending/reaching

____With cold weather
____Hearing running water
____ With nervousness/anxiety

____ Other,_____

14. Is there anything that makes your symptoms better? _____
15. Do you have a previous history of similar symptoms? _____
16. Describe any previous treatment/exercises:_____
    Did you benefit with previous treatment? Y/N
17. What are your goals for physical therapy? _____

Bladder/Bowel Habits/Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent/slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination

Y/N Constant urine leakage
Y/N Blood in urine
Y/N Painful urination
Y/N Current laxative use
Y/N Trouble feeling bladder urge/fullness
Y/N Pain with full bladder
Y/N Trouble feeling bowel/urge/fullness
Y/N Trouble holding back gas/feces
Y/N wetting the bed
Y/N Urge to urinate (mild/moderate/strong)
Y/N Recurrent bladder infections; if yes then how many per year_____
Y/N Feel unable to empty your bladder completely

1. Frequency of urination:
   ____# of times per day
   ____# of times per night
2. How long can you delay urinating before having to go to the restroom?
   _____minutes
   _____hours
   _____not at all
3. How much urine do you usually pass?
   _____small _____medium _____large
4. Frequency of bowel movements
   _____# of times per day, _____# of times per week, or_____
5. How long can you delay having a bowel movement once you have an urge before having to go to the restroom?
   _____minutes
   _____hours
   _____not at all
6. If constipation is present please describe management techniques:
   _____
   _____

7. Average fluid intake (1 glass = 8 ounces = 1 cup) _____ glasses per day
   Of this total how many glasses are caffeinated? _____ glasses per day

Skip questions if no leakage/incontinence

8. Bladder leakage: number of episodes
   ____No leakage
   ____Times per day
   ____Times per week
   ____Times per month
   ____Only with physical exertion/cough/laugh/sneeze/lift
9. On average, how much urine do you leak?
   ____No leakage
   ____Just a few drops

____Wets underwear
____Wets outerwear
____Wets the floor

10. Bowel leakage: number of episodes
    ____No leakage
    ____Times per day
    ____Times per week
    ____Times per month
    ____Only with physical exertion/cough/laugh/sneeze/lift
11. Rate of feeling of organ "falling out"/prolapse or pelvic heaviness/pressure:
    ____None present
    ____Times per month (specify if related to activity or your period)
    ____With sitting for minutes or hours
    ____With standing for minutes or hours
    ____With exertion or straining
    ____Other
12. How much stool do you lose?
    ____No leakage
    ____Stool staining
    ____Small amount in underwear
    ____Complete emptying

13. What form of protection do you wear?
    ____None
    ____minimal protection (Tissue paper/paper towel/pant shields)
    ____Moderate protection (absorbent product, maxi pad)
    ____Maximum protection (Specialty product/diaper)
    ____Other_____
    On average, how many pad/protection changes are required in 24 hours?__of pads

<u>Surgical/Procedure History</u>

Y/N Surgery for your back/spine Y/N Surgery for your brain
Y/N Surgery for your female or male organs Y/N Surgery for your bladder/prostate
Y/N Surgery for your bones/joints Y/N Surgery for your abdominal organs
Other/describe:_____

<u>Ob/Gyn History (females only)</u>

Y/N Childbirth vaginal deliveries #_____ Y/N Episiotomy #_____
Y/N C-Section #_____ Y/N Difficulty childbirth #_____
Y/N Prolapse or organ falling out Y/N Vaginal dryness
Y/N Vaginal itching Y/N Painful periods
Y/N Menopause: when_____

Y/N Painful vaginal penetration
Y/N Pelvic pain Y/N Abdominal pain
Y/N Miscarriages_____

Males only
Y/N Prostate disorder
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other/describe_____

General Health History
Date of Last Physical Exam_____

Tests Performed and results:
Y/N Urodynamics test:_____
Y/N Cystoscope:_____
Y/N Urine test: _____
Y/N Bowel test:_____
Other:_____
_____

Since the onset of your current symptoms have you had any of the following occur? (Please circle all that apply)
Y/N Unexplained weight change
Y/N Night pain/sweats
Y/N Fever/chills

Y/N Muscle weakness
Y/N Unexplained tiredness
Y/N Dizziness or fainting

Y/N Numbness or tingling
Y/N Change in bowel or bladder functions
Y/N Other_____

Have you ever had or have any of the following conditions or diagnoses (Please circle all that apply):

Medications (pills, patches, injections, creams/ointment, over the counter, vitamins) or bring attached list

_____
_____
_____
_____
_____

Cancer	Epilepsy/seizures	Arthritic conditions
Heart problems	Multiple sclerosis	Joint replacement
High blood pressure	Head injury	Bone fractures
Ankle swelling	Osteoporosis	Sports injuries
Anemia	Chronic Fatigue Syndrome	TMJ/neck pain
Low back pain	Fibromyalgia	Allergies
Sacroiliac/Tailbone pain	Acidic reflux/belching	Latex sensitivity
Alcoholism/Drug Problem	Emphysema	Glue or lotion sensitivity
Childhood bladder problems	Chronic Bronchitis	Hypothyroid/hyperthyroid
Depression	Asthma	Headaches
Anorexia/bulimia	Diabetes	Hepatitis
Smoking history	Kidney disease	STD (Sexually transmitted disease)
Vision/eye problems	Thoracic, upper back, or rib pain	Physical or Sexual abuse
Hearing loss/problems	Stress fracture	HIV/AIDS
Stroke	Shoulder pain: right or left	Raynaud's (cold hands/feet)
Foot pain: right or left	Knee pain: right or left	Pelvic pain
Ankle pain: right or left	Hip pain: right or left	PTSD
Hand pain: right or left		BPV
Wrist pain: right or left		Other:_____