

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name: _____ Why are you here? _____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	MEDICAL PROBLEMS	√	CHILDBEARING HISTORY	
Heart Disease/Surgery		Diabetes		Are you Pregnant? Yes No If yes, what is your due date: _____	
<input checked="" type="checkbox"/> High Blood Pressure				# of Children (circle one number)	0 1 2 3 4 5 +
Pain/tightness in chest		Cancer		# of Vaginal deliveries (circle)	0 1 2 3 4 5 +
Cold Hands/feet		<input checked="" type="checkbox"/> Dizziness		# of C-Sections (circle one number)	0 1 2 3 4 5 +
		Thyroid Problems		# of episiotomies (circle one number)	0 1 2 3 4 5 +
<input checked="" type="checkbox"/> Numbness in hands/feet		<input checked="" type="checkbox"/> Falls the last 6 mos.		# of forceps deliveries	0 1 2 3 4 5 +
		<input checked="" type="checkbox"/> # trips/slips/near falls		Birth weight of largest baby	
BONES & JOINTS		<input checked="" type="checkbox"/> Depression		GYNECOLOGICAL HISTORY	
Chronic Fatigue Syndrome				Date of Last Pap Smear: _____	
Arthritis					
Fibromyalgia		LUNG/BREATHING		History of Candida/Genital Herpes/ Yeast	Yes No
Tailbone pain		Shortness of Breath		Do you have any current infections or yeast	Yes No
		Smoke cigarettes now		Do you use Bath salts, vaginal sprays, deodrant	Yes No
AREAS OF PAIN		History of smoking		Do you use vaginal lubricants or ___KY jelly	Yes No
Back				Do you use latex condoms	Yes No
Neck/shoulders		SURGICAL HISTORY			
Rectum		Back or neck		URINARY/BLADDER HISTORY	
Abdomen/belly		Tubal Ligation		Do you urinate more than once every 2 hours?	Yes No
Vagina		Laproscopy		Do you have a sense of "urgency" to urinate?	Yes No
Vulvar area (around the vagina)		Abdominal Hysterectomy		Do leak urine with ___cough ___ laugh ___sneeze ___exercise ___lifting ___Other _____	
ALLERGIES		Vaginal Hysterectomy		Do you have interstitial cystitis	Yes No
Ragweed		Gall Bladder		How many times do you urinate at night?	1 2 3 4 5+
Food allergies		Bladder surgery		Do you trouble starting a urine stream?	Yes No
Latex allergies		Pelvic Surgery		Do you have a falling out feeling ___Yes ___No If yes ___Sometimes with menses ___Standing ___Straining ___At the end of the day ___All the time	
Seasonal Allergies		Vaginal Surgery/laser		How often do you urinate during the day	
SKIN CONDITIONS		Vulvar Surgery		BOWEL HISTORY	
Eczema					
Contact Dermatitis		FAMILY HISTORY		Do you leak gas or feces	Yes No
Psoriasis		Skin cancer		Do you have constipation	Yes No
Lichens Simplex		Allergies		Is your stool ___Liquid ___Soft (like peanut butter) ___Firm (like banana) ___Hard	
Other				How often do you have a bowel movement: ___2 or more x per day ___Daily ___Every other day ___Every 4-7 days	

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: Single Married Separated Divorced Dating

Do you feel safe at home? Yes No Comment: _____

Occupation: _____ Physically this means I sit stand walk most of the day

Educational Level _____ **Hobbies:** _____

EXERCISE HISTORY:

No exercise Walk _____ Go to gym _____

Other _____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Happy →		Calm →		Unmotivated		Stressed		Lonely		Content		Depressed	
Overwhelmed →		Sad →		Tired		Afraid		Energetic		Optimistic		“Postpartum blues”	
Flabby →		Strong →		Un-rested		Lethargic		Weak		Overworked		Not bonding with baby(ies)	
Anxious →		Unsafe →		Abused		Neglected							

HOW DO YOU LEARN?: Listening (lecture, discussion) Seeing (read, video, DVD) Doing (practicing skill)

Is English your primary language? Yes No. If no, would you need a translator when you are in therapy? _____

NUTRITION: How much do you weigh? _____ pounds

Would you like to <input type="checkbox"/> lose or <input type="checkbox"/> gain weight?	Yes No	
Have you gained/ lost more than 10 pounds in the last year?	Yes No	
Are you on any special diet?	Yes No	<input type="checkbox"/> Low Carb <input type="checkbox"/> Atkins <input type="checkbox"/> South Beach <input type="checkbox"/> Weight Watchers <input type="checkbox"/> Diabetic <input type="checkbox"/> Other _____
Would you say your diet is “unhealthy”?	Yes No	<input type="checkbox"/> too many fast foods <input type="checkbox"/> Not enough vegetables <input type="checkbox"/> High Fat <input type="checkbox"/> High Carb <input type="checkbox"/> Other _____

FLUID INTAKE: What do you drink every day?

8 ounce glasses of water cans of diet soda cans of regular soda 8 ounce cups of regular coffee
 8 ounce cups of decaffeinated coffee 8-ounce cups/glasses of tea 16-ounce cans of beer
 glasses of wine glasses of liquor 8-ounce glasses of milk 8-ounce glasses of juice _____
 Other _____

Anything else you would like us to know about you? _____

TELL US HOW YOUR BLADDER PROBLEM AFFECTS YOUR DAILY LIFE?

Please check the appropriate box. If any statement does not apply to you, leave that box blank.

- (1) Not at all (2) Slightly (3) Moderately (4) A lot

My bladder problem :	1	2	3	4
Affects the way I dress				
Affects my ability to do my housework (cleaning, shopping, carrying)				
Affects my ability to travel more than one hour without stopping to use the bathroom				
Interferes with my social life (interrupted movies, dancing, going to worship, gatherings)				
Affects my relationship with my partner				
Affects my sex life				
Makes me feel (circle all that apply) depressed anxious embarrassed frustrated angry				
Affects my job or activities outside my home				
Affects my sleep				
Makes me worry that I smell				
Affects the amount of fluids that I drink				

Initial Score ___/44

Score at discharge ___/44

TELL US ABOUT YOUR BLADDER SYMPTOMS

There are five questions. Circle one number 0-4 that most accurately describes your symptoms:

<p><u>How Often do you leak urine?</u></p> <p>0 Never 1 1-4 times per month 2 2-4 times per week 3 Once per day 4 More than once per day</p>	<p><u>How much urine do you leak?</u></p> <p>0 None 1 Few drops 2 Enough to soak a panty liner or underwear 3 Enough to soak a pad or wet outerwear 4 Runs down my leg or wets the floor</p>
<p><u>What type of pads/protection do you wear?</u></p> <p>0 I do not wear any pads or panty liners 1 I wear a panty liner 2 I wear mini pads 3 I wear a maxi pad 4 I wear heavy pads like Depends/Poise or diapers</p>	<p><u>How many pads do you use?</u></p> <p>0 I do not use any pads or panty liners 1 I only use pads during certain activities 2 I use 1 pad per day 3 I use 2-4 pads per day 4 I use more than 4 pads per day</p>
<p><u>How often do you get up at night to urinate?</u></p> <p>0 0-1 time per night 1 1-2 times per night 2 3-4 times per night 3 5-6 times per night 4 More than 6 times per night</p>	<p><u>Activity that Causes Urine Loss</u></p> <p>0 No activity causes leakage 1 Light Activity causes leakage 2 Moderate Activity causes leakage 3 Vigorous Activity causes leakage 4 Leak with all physical effort</p>

Initial Score ___/20

Final Score ___/20

CURRENT SEXUAL ACTIVITY:

Sexually Inactive due to PAIN Sexually inactive due to bladder problem Sexually active

If you are sexually active, continue with this section.

No pain with intercourse Pain with intercourse, able to complete coitus Pain with intercourse disrupts or prevents coitus
 Pain with intercourse prevents any attempt at coitus

CHECK ALL THE ACTIVITIES THAT CAUSE OR INCREASE YOUR PAIN: No Pain or Pain with:

Gynecological Examination with Speculum Urination after intercourse Finger insertion into vagina
 Tampon insertion Tampon removal Partner manual stimulation Friction with clothing Sports activity
 Urination in general Wearing pads
 Other _____

CHECK THE WORDS THAT DESCRIBE YOUR PAIN: No Pain or Pain is:

Hot Burning searing Sharp Tiring Exhausting frightful punishing Annoying
 Troublesome miserable intense unbearable discomfoting Other _____

WHAT MAKES YOUR PAIN BETTER: NO Pain or Pain is relieved with:

Heating pad Ice pack Resting in bed Resting in Chair Medication Cream _____
 Abstaining from sexual intercourse Not using tampons Not wearing tight clothes other _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Surgery	Yes No A little
Physical Therapy	Yes No A little	Other	Yes No A little

What started this problem? _____

Comments

