Urinary Incontinence Program Patient History Questionnaire

Patient:	 	 	
N 1 D 44.			



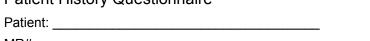
MR#:	
Your therapist will discuss your responses with you during the evaluation. Thank yo	ou for completing this information.
PERSONAL INFORMATION	
I am currently:	ave Not employed
Employer: Occupation:	
Interests/Hobbies:	
Best way to reach me: Phone E-mail (address)	
Living arrangements: Do you live alone?	
Any additional information you feel would help us provide your care (i.e., What you spiritual or cultural needs):	
Next scheduled Dr. Appointment: Date: Physician: PERSONAL GOALS FOR THERAPY:	
KEY QUESTIONS ABOUT YOUR CONDITION What is your MAIN complaint? Are you experiencing any pain? Yes No If Yes, please describe	
When did your problem first begin or become worse?// Since then is it What are your feelings about your urinary incontinence on the scale of 1 to 10 listed	
0 1 2 3 No impairment/inconvenience/embarrassment	
Medical History: (check all that apply)	·
heart disease arthritis sexually transmitted disease	high blood pressure pelvic pain
□ pacemaker □ low back pain □ stroke or multiple sclerosis □ lung/breathing problems □ cancer (type)	☐ HIV/AIDS ☐ diabetes ☐ fractures Other:
	fractures Other:
Surgical History: (check all that apply) □ back/neck surgery □ bladder repair □ kidney surgery □ hernias hysterectomy: □ abdominal or □ vaginal	appendectomy gallbladder surgery
Gynecological History:	
# of pregnancies: # of vaginal deliveries:	Length of time pushing:
# of episiotomies: Do you have a painful episiotomy scar?	☐ Yes ☐ No
# of C-sections: Pelvic Pain? Yes No	Painful vaginal penetration? Yes No
Do you have a history of urinary tract infections? ☐ Yes ☐ No	Organ prolapse? ☐ Yes ☐ No
When was your menopause onset?	
Do you have a history of urine loss? \square as a child \square as an adolescent \square after	childbirth

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		PHYSIC/	PHYSICAL THERAPY			
Do you have any allergies (e.g. Adhesives, latex, cortisone)? Reaction/T Reaction/T For patients 12 years and younger, is immunization/vaccination status of the company o						
Reaction/T Reaction/T For patients 12 years and younger, is immunization/vaccination status of the property						
Reaction/T For patients 12 years and younger, is immunization/vaccination status of the state o	No If <u>yes</u> , please li	st any reactions/tr	eatments:			
Reaction/T For patients 12 years and younger, is immunization/vaccination status of the state o	reatment					
For patients 12 years and younger, is immunization/vaccination status of the state						
Have you been on Hormone Replacement Therapy?	reatment					
Dosage: Estrogen Progesterone Previous Treatment for Incontinence:	urrent?	Yes No				
		: Pills Pa	itch			
you do no one of control difficions:	☐ Yes ☐	No				
Has your doctor prescribed any medication to treat urine loss?	☐ Yes ☐	No				
Have you had any surgical procedures to treat urine loss?	☐ Yes ☐	No				
Do you experience a loss of urine Never	Sometimes	Always]			
With coughing, laughing, sneezing?			1			
When lifting objects?			_			
With exercise, running, etc.?						
When you have a strong urge to urinate?						
On the way to the bathroom?						
With "key in lock"?						
Just as getting to the toilet/removing clothes?						
Do you						
Experience an urge to urinate when you hear running water and then you are unable to get to the toilet?						
Have difficulty initiating a urine stream?						
Have difficulty stopping your stream?						
Have pain with urination?						
Have burning with urination?						
Oo you						
Have blood in your urine?]			
Have to strain to empty your bladder?						
Dribble urine when you are urinating?						
Feel like organs are falling out or feel pelvic pressure						
Vhen you urinate Small	Medium	Large				
Usual amount of urine voided (planned toileting)			1			
Usual amount of urine voided with accident						
		.1	<u> </u>			
Frequency of Urination Planned toileting: Number of times/awake hours						
Incontinence/accidents: Number of episodes/awake hours	Number of times/sle	ep hours				

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MR#:					
Bustontino Bosinos					
Protective Devices: Panty liner: ☐ Yes	s □ No				
Incontinence Pad:	☐ Poise	☐ Attends	☐ Serenity		
Sanitary Pad:	☐ Mini	☐ Maxi	☐ Incontinence	Brief	
Number of pads us	ed each day?		Do you soak the	e pad fully?	No
Do you change the	pad each time it	's wet? Yes	□ No		
Daily Fluid Intake:					
-	r dav	Of those, how man	v are caffeinated?	carbonated?	
Do you restrict fluid	•		•		
Bowel Habits:					
How often do you h	ave a bowel mo	vement?			
Are you ever consti		☐ Yes ☐ No			
How do you resolve	-				
Do you experience	· · · · · · · · · · · · · · · · · · ·				
Do you use laxative				veek?	
Do you use enema		☐ Yes ☐ No		/eek?	
•			, etc.)? Yes No		
Function/Mobility/Self-0	Care:				
Do you: Use a ca		es 🗌 No	Do vou have difficulty:	With getting on/off the toilet?	☐ Yes ☐ No
Use a wa		es 🗌 No	. ,	With getting clothes on/off?	☐ Yes ☐ No
		nce? 🗌 Yes 🗆	l No	With toilet Hygiene?	☐ Yes ☐ No
			continence?		
Please explain:	-	•			
To the best of my know	ledge, the abov	e information is co	omplete and factual.		
Patient Signature				 Date	