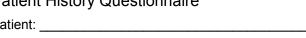
Urinary Incontinence Program Patient History Questionnaire





Patient: _____ MR#: _____ Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information. PERSONAL INFORMATION I am currently:

Employed Employed with restrictions On medical leave Not employed _____ Occupation: _____ Interests/Hobbies: Best way to reach me: Phone E-mail (address) Is there anyone who can assist you with doing home exercises or activities if needed? Yes No Will you have any problems attending therapy sessions? Yes No If yes, please describe: Any additional information you feel would help us provide your care (i.e., What you think would help, any apprehensions about treatment, spiritual or cultural needs): Date: _____ Physician: _____ Next scheduled Dr. Appointment: PERSONAL GOALS FOR THERAPY: **KEY QUESTIONS ABOUT YOUR CONDITION** What is your MAIN complaint? _____ When did your problem first begin or become worse? / / Since then is it: Better Worse Same What are your feelings about your urinary incontinence on the scale of 1 to 10 listed below? 10 No impairment/inconvenience/embarrassment Severe impairment/inconvenience/embarrassment **Medical History**: (check all that apply) heart disease arthritis high blood pressure sexually transmitted disease pelvic pain diabetes low back pain stroke or multiple sclerosis ☐ HIV/AIDS pacemaker cancer (type) ☐ lung/breathing problems ☐ fractures Other: **Surgical History**: (check all that apply) back/neck surgery bladder repair kidney surgery appendectomy qallbladder surgery hernias hysterectomy: abdominal or vaginal **Gynecological History**: Length of time pushing: # of pregnancies: # of vaginal deliveries: # of episiotomies: _____ ☐ Yes ☐ No Do you have a painful episiotomy scar? Pelvic Pain? ☐ Yes ☐ No Painful vaginal penetration? ☐ Yes ☐ No # of C-sections: ☐ Yes ☐ No Organ prolapse? ☐ Yes ☐ No Do you have a history of urinary tract infections? When was your menopause onset? Do you have a history of urine loss? ☐ as a child ☐ as an adolescent ☐ after childbirth

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	PEAK PERFORMANCE SPORTS and PHYSICAL THERAPY
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Patient:				and Phisical
MR#:				
Current Medications: (Prescription, non-prescription):				
Do you have any allergies (e.g. Adhesives, latex , cortisone)		-	•	
	Reaction/Treatr	nent		
For patients 12 years and younger , is immunization/vaccina	ation status currer	t? \	∕es □ No	
Have you been on Hormone Replacement Therapy? Dosage: Estrogen Progester	☐ Yes ☐ No		Pills Pa	ıtch
Previous Treatment for Incontinence:			NI.	
Have you done exercises to control urine loss?	0	∐ Yes ∐		
Has your doctor prescribed any medication to treat uring la		∐ Yes ∐		
Have you had any surgical procedures to treat urine lo	55 (∐ Yes ∐	INU	
Do you experience a loss of urine	Never	Sometimes	Always]
With coughing, laughing, sneezing?				
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?				
Oo 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?				
Do you				_
Have blood in your urine?				
Have to strain to empty your bladder?				
Dribble urine when you are urinating?				1
Feel like organs are falling out or feel pelvic pressure				
When you urinate	Small	Medium	Large	
Usual amount of urine voided (planned toileting)				
Usual amount of urine voided with accident				1
	L		<u> </u>	_
Frequency of Urination Planned toileting: Number of times/awake	hours N	lumber of times/sle	ep hours	
•	Incontinence/accidents: Number of episodes/awake hours Number of episodes/sleep hours			ıro

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Patient:					
MR#:	 				
Protective Devices:					
Panty liner: ☐ Yes ☐ No					
Incontinence Pad:	☐ Attends	☐ Serenity			
Sanitary Pad:	☐ Maxi	☐ Incontinence Brief			
Number of pads used each day?		Do you soak the pad fully? ☐ Yes ☐ No			
Do you change the pad each tim	e it's wet? Yes	No			
Daily Fluid Intake: Number of cups per day Do you restrict fluids because of		are caffeinated? carbonated?			
Bowel Habits:					
How often do you have a bowel i	movement?				
Are you ever constipated	☐ Yes ☐ No				
How do you resolve this?					
,	☐ Yes ☐ No				
<u>.</u>	Do you use laxatives?				
Do you use enemas? Yes No How often per week?					
Do you include fiber in your diet	(fruit, vegetables, bran, e	tc.)? Yes No			
Function/Mobility/Self-Care:					
Do you: Use a cane?	Yes No	Do you have difficulty: With getting on/off the toilet? Yes No			
Use a walker? ☐	Yes 🗌 No	With getting clothes on/off? ☐ Yes ☐ No			
Lean on furniture for b	alance? 🗌 Yes 🔲 I	No With toilet Hygiene? ☐ Yes ☐ No			
Have you had to restrict your act	ivities due to urinary inco	ontinence?			
Please explain:					
To the best of my knowledge, the ak	pove information is con	nplete and factual.			
Patient Signature		Date			