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

Employer: _____ Occupation: _____

Interests/Hobbies: _____

Best way to reach me: ☐ Phone ☐ E-mail (address) _____

Living arrangements: Do you live alone? ☐ Yes ☐ No

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): _____

_____

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: ☐ Better ☐ Worse ☐ Same

What are your feelings about your urinary incontinence on the scale of 1 to 10 listed below?

0 1 2 3 4 5 6 7 8 9 10

No impairment/inconvenience/embarrassment *Severe 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 ☐ HIV/AIDS ☐ diabetes

☐ lung/breathing problems ☐ cancer (type) _____ ☐ fractures Other: _____

Surgical History: (check all that apply)

☐ back/neck surgery ☐ bladder repair ☐ kidney surgery ☐ appendectomy ☐ gallbladder surgery

☐ hernias hysterectomy: ☐ abdominal or ☐ vaginal

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? ☐ as a child ☐ as an adolescent ☐ after childbirth

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Current Medications: (Prescription, non-prescription):_____

_____

_____

Do you have any allergies (e.g. Adhesives, **latex**, cortisone)? ☐ Yes ☐ No If yes, please list any reactions/treatments:

_____ Reaction/Treatment _____

_____ Reaction/Treatment _____

For patients **12 years and younger**, is immunization/vaccination status current? ☐ Yes ☐ No

Have you been on Hormone Replacement Therapy? ☐ Yes ☐ No

Dosage: Estrogen _____ Progesterone _____ Type: ☐ Pills ☐ Patch ☐ Cream

Previous Treatment for Incontinence:

Have you done exercises to control urine loss? ☐ 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?			
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?			
Do 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			
When you urinate . . .	**Small**	**Medium**	**Large**
Usual amount of urine voided (planned toileting)			
Usual amount of urine voided with accident			

Frequency of Urination

Planned toileting: Number of times/awake hours _____ Number of times/sleep hours _____

Incontinence/accidents: Number of episodes/awake hours _____ Number of episodes/sleep hours _____

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Protective Devices:

Panty liner: ☐ Yes ☐ No

Incontinence Pad: ☐ Poise ☐ Attends ☐ Serenity

Sanitary Pad: ☐ Mini ☐ Maxi ☐ Incontinence Brief

Number of pads used each day? _____ Do you soak the pad fully? ☐ Yes ☐ No

Do you change the pad each time it's wet? ☐ Yes ☐ No

Daily Fluid Intake:

Number of cups per day _____ Of those, how many are caffeinated? _____ carbonated? _____

Do you restrict fluids because of your incontinence? ☐ Yes ☐ No

Bowel Habits:

How often do you have a bowel movement? _____

Are you ever constipated ☐ Yes ☐ No

How do you resolve this? _____

Do you experience diarrhea? ☐ Yes ☐ No

Do you use laxatives? ☐ Yes ☐ No How often per week? _____

Do you use enemas? ☐ Yes ☐ No How often per week? _____

Do you include fiber in your diet (*fruit, vegetables, bran, etc.)?* ☐ Yes ☐ No

Function/Mobility/Self-Care:

Do you: Use a cane? ☐ Yes ☐ No

Use a walker? ☐ Yes ☐ No

Lean on furniture for balance? ☐ Yes ☐ No

Do you have difficulty: With getting on/off the toilet? ☐ Yes ☐ No

With getting clothes on/off? ☐ Yes ☐ No

With toilet Hygiene? ☐ Yes ☐ No

Have you had to restrict your activities due to urinary incontinence? ☐ Yes ☐ No

Please explain: _____

To the best of my knowledge, the above information is complete and factual.

_____ _____

Patient Signature Date