Urinary Incontinence Program
# Patient History Questionnaire

advent PHYSICAL THERAPY

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