PELVIC HEALTH INTAKE FORM

Name ______________________________ Date _______________

DOB ______________________________ Age _______________

What is your gender? ____

What sex were you assigned at birth? ____

URINARY FUNCTION

I estimate __________ **voids per day &** __________ **per night.**

I leak urine when I:

cough   yell   exercise   move from sitting to standing
sneeze   jump   laugh   vomit   Other _____________

I constantly leak urine.   Yes   No   Sometimes

I sometimes I am unable to make it to the toilet in time because the urge is so strong that I leak urine.

Yes   No   Sometimes

Things that trigger my urge include:

running water   cold   Other ____________________
key in the door   the bathroom

I have a ...   constant stream   intermittent stream   **of urine when I urinate.**

I have a difficulty ...   starting   stopping   **my flow.**

I have to ...   strain   self-cath   **to completely empty my bladder.**

I empty my bladder when I urinate.   Yes   No   Sometimes

I wear pads for my urinary incontinence.   Yes   **How many?** __________   No   Sometimes

I do pelvic floor exercises (kegels).   Yes   No   Sometimes

BOWEL FUNCTION

I typically have __________ **bowel movements per**   week   day

I leak   gas   stool

I wear pads for my fecal incontinence.   Yes   **How many?** __________   No   Sometimes

I have irritable bowel syndrome. Yes No

I typically have... constipation diarrhea mixed

To manage constipation I use... ______________________________

I sometimes am unable to make it to the toilet in time because the urge is so strong that I leak feces.

Yes No Sometimes

Things that trigger my urge include:

eating cold key in door Other ______________
caffeine running water the bathroom

I have to splint my perineum with my hand when I have a bowel movement.

Yes No Sometimes

I have to manually evacuate stool on occasion.

Yes No Sometimes

I am experiencing rectal bleeding and/or blood in my stool.

Yes No Sometimes

NUTRITION, FLUID & EXERCISE INTAKE

I drink ________ servings of water per day. (1 serving = 8 ounces)

I drink the following servings of beverages a day:

soda ________ decaf coffee ________
diet soda ________ tea ________
milk ________ alcohol ________
regular coffee ________ other ______________

I weigh ________ pounds.

I am currently dieting. Yes **What diet?** ______________ No

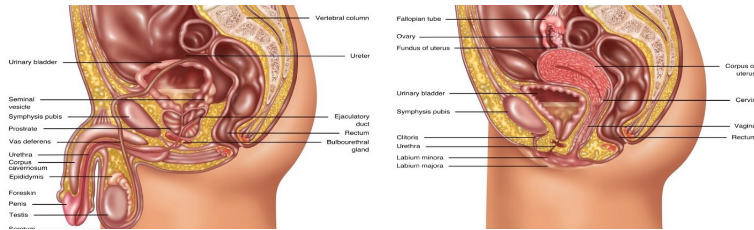
I exercise ________ times per week.

I typically do the following exercises: ______________________________

I have had/have an eating disorder. anorexia bulimia other ______________

PAIN & SEXUAL HEALTH HISTORY

Please shade the areas of pain on the anatomy you have a write a number from 1 to 10 at the site(s) of pain. (10 = most severe)



I have problems with pain. Yes No Sometimes

I am sexually active at this time. Yes No Sometimes

I am sexually inactive due to pain. Yes No Sometimes

I am sexually inactive for other reasons. Yes No Explain ______________________________

Please answer the following if it applies to you:

My pain is worse during an erection. Yes No Sometimes

My pain is worse during ejaculation. Yes No Sometimes

My pain lingers after ejaculation for __________ days hours minutes.

My pain is located:

rectal area penis testicles my pain feels deep inside
abdomen behind testicle buttock

I have pain after intercourse. This pain includes:

backache when my bladder is full pain with sitting other __________
muscle/joint pain pain with urination migraine headache

Please answer the following if it applies to you:

I have pain during ovulation. Yes No Sometimes

My pain is worse during ovulation. Yes No Sometimes

I have pain during my period. Yes No Sometimes

My pain is worse just before my period. Yes No Sometimes

I have pain during intercourse.

my pain feels close to the vaginal opening pain with orgasm
my pain feels deep inside me other __________

I have pain after intercourse.

when my bladder is full burning vaginal pain after sex backache pain with sitting
muscle/joint pain pain with urination migraine other __________

GYNECOLOGICAL HISTORY

The first day of my last menstrual cycle was __________ .

Have you currently started your menstrual cycle? Yes No

During menstruation, my periods are:

light heavy
moderate bleed through protection

Do you use birth control? Yes No

I am currently using the following birth control method:

IUD birth control pill Nuva Ring other___________
condoms Depo Provera shot withdrawal

I have not started menopause. Yes No

I have started completed menopause.

Do you have history or a current medical concern? (including pelvic heaviness, fibroids, cysts, or endometriosis)

____

OBSTETRIC HISTORY

I am currently pregnant. Yes No have been

If answered no, please skip this section.

I'm at ___________ weeks gestation, with the due date of ___________ .

Do you have concerns during this pregnancy?

____

Has your physician placed you on any restrictions?

____

Number of pregnancies ___________ (including current, if applicable)

vaginal deliveries___________ miscarriages ___________

cesarean deliveries ___________ abortions ___________

episiotomies ___________

What complications did you experience during pregnancy during labor, delivery, or postpartum?

vacuum medication for bleeding forceps other___________
postpartum hemorrhaging postpartum depression preeclampsia

Fill out this section ***ONLY*** *if you have given birth in the last 12 weeks.*

IN THE LAST 7 DAYS:

I have blamed myself unnecessarily when things go wrong.

yes, all the time
yes, most of the time
no, not very often
no, not at all

I have felt panicky or scared for no good reason.

yes, all the time
yes, most of the time
no, not very often
no, not at all

I have been anxious or worried for no good reason.

yes, all the time
yes, most of the time
no, not very often
no, not at all