Physio4U Move More. Do More.
459 23rd Street Brandon, MB reception@physio4u.net 204-725-4066

FEMALE SYMPTOM MONITOR

Name: ____________________ Date: ____________________

Occupation: ____________________ Age: ____ DOB: ____________

Complaints: 1. ____

2. ____

3. ____

When did this start: ____

GYNECOLOGICAL HISTORY:

pregnancies: ___ # live births: ___ Wt. heaviest baby: ___ lbs ___ oz Length pushing stage: ___ hours

Forceps? ☐ Yes ☐ No Episiotomies? ☐ Yes ☐ No Tears? ☐ Yes ☐ No

HRT? ☐ Yes ☐ No When? ________ Last pap: ____________ Normal? ☐ Yes ☐ No

Sexually Active? ☐ Yes ☐ No Pain with sex? ☐ Yes ☐ No When? ☐ Penetration ☐ Thrusting?

Birth Control Method: ____________________ C-Section: ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No If yes, ☐ Trouble falling to sleep? ☐ Trouble Staying Asleep?

Do you have feelings of heaviness or pressure in your vagina? ☐ Yes ☐ No
Has anyone ever told you that you have a prolapse? ☐ Yes ☐ No

SURGICAL HISTORY:

Abdominal: ☐ When: ____

Pelvic: ☐ When: ____

BLADDER SYMPTOMS: Please put an X next to the statements that best describe your symptoms:

My incontinence is associated with activities such as sneezing, running or laughing ☐ daily ☐ weekly
S
My leakage occurs after having a strong voiding sensation that feels uncontrollable ☐ daily ☐ weekly
U
I void during the day more than the average person (>5-7 X/day) __________ # times per day
F
My bladder troubles cause me to go to the bathroom at night __________ # times/night
N
My bladder problems cause me to leak at night __________ # times/week
My incontinence requires me to wear pads __________ # pads/day

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When I void, I don't empty completely and feel like I have to go again soon ☐ Yes ☐ No ☐ Sometimes
R
I have pain when I urinate ☐ Yes ☐ No ☐ Sometimes
PBS
I have to strain when I urinate ☐ Yes ☐ No ☐ Sometimes
TP
I have leakage during intercourse ☐ Yes ☐ No ☐ Sometimes
S
I had problems with my bladder during my childhood ☐ Yes ☐ No

I feel overwhelmingly strong sensations prior to voiding but I don't leak ☐ Yes ☐ No
U
Fluid Intake in 24 hours:

#____cups of coffee/day #____cups of water/day #____cups of tea/day # _____ cups of other fluids/day

BOWEL HISTORY:

Frequency: /week

Fecal Incontinence: ☐ Yes ☐ No Stool Consistency: ☐ Loose ☐ Soft/formed ☐ Hard ☐ Varies

Fecal Urgency: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

MEDICAL HISTORY:

Urinary Tract Infections: ☐ Yes ☐ No Antibiotics Recently? ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No ___ #packs/day

Chronic Cough: ☐ Yes ☐ No

Do you get blood in your urine: ☐ Yes ☐ No

Allergies (including latex): ____

Height: ____ ft. ____ In. Weight: _______ lbs BMI: ______________(therapist)

Back Problems: ☐ Yes ☐ No
If yes, please ask the receptionist for the Pelvic Girdle Assessment Form

Neck Problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

On a scale from 1-10, please circle and rate your current pain/discomfort

1 2 3 4 5 6 7 8 9 10