Patient Name:_____ **Date:**_____/_____/_____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you during your appointment.

HISTORY

Number of pregnancies _____

Number of vaginal deliveries: _____

Number of cesarean deliveries: _____

Number of episiotomies: _____

Date of last pap smear: _____/_____/_____

History of STD's: Y N If yes, please indicate:_____

Did you have any trouble during pregnancy or delivery	Y	N
If yes, please explain:		
Do you have any history of sexual abuse or trauma?	Y	N
Are you having regular periods or menstrual cycles?	Y	N
Do you have frequent urinary tract infections?	Y	N

PAIN

Do you have pain with:		
Sexual intercourse:	Y	N
Pelvic Exams:	Y	N
Tampon Use:	Y	N
Do you have pain in the back, leg, groin, and/or abdominal?	Y	N
If yes, please describe:		

PEAK PERFORMANCE Physical Therapy

TEST RESULTS:

Urodynamics Test:	Y	N	Results:
Cystoscope:	Y	N	Results:
Urine Test:	Y	N	Results:
Bowel Test:	Y	N	Results:

BLADDER SYMPTOMS:

Do you lose urine when you:		
Cough, laugh, sneeze	Y	N
On the way to the bathroom	Y	N
Hear running water	Y	N
Lift/Exercise/dance	Y	N
Have strong urge to urinate	Y	N
Other	Y	N

Do you:

Wet the bed	Y	N
Have burning/pain with urination	Y	N
Difficulty starting stream	Y	N
Strain to empty your bladder	Y	N
Feel unable to empty bladder fully	Y	N
Have a falling out feeling	Y	N
Have pain with a full bladder	Y	N
Have an urgency of urination	Y	N
Urinate more than 7x a day	Y	N

PEAK PERFORMANCE Physical Therapy

BOWEL SYMPTOMS:

Strain to have bowel movement:	**Y**	**N**
Include fiber in your diet:	Y	N
Take laxatives/enema regularly	Y	N
Have pain with bowel movement	Y	N
Have very strong urge to move bowels	Y	N
Leak feces	Y	N
Have diarrhea often	Y	N
Leak gas by accident	Y	N

How often do you move your bowels _____times a day

Most Common stool consistency:

_____ Liquid _____Soft _____Firm _____Pellets _____Other _____

Any other comments or concerns:

_____

_____

_____