



# Medical History and Status Questionnaire

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

What are we seeing you for (where is your pain)? \_\_\_\_\_

When did your pain start (approx)? \_\_\_\_\_ Has the pain gotten any better, worse, or no change? \_\_\_\_\_

## What does the pain/dysfunction limit you from doing?

	Never Interferes	10-20% of the time	30-40% of the time	50-60% of the time	70-80% of the time	Always Interferes
Household Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activities/Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking or Moving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing or Sitting through long events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep (# of times sleep is interrupted)	<input type="checkbox"/> 0x	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5+x

Are you taking any medication for this problem (if yes, what kind)? \_\_\_\_\_

Please rate your pain level from 0-10 (0=no pain, 10=hospitalizing pain): now \_\_\_\_\_ at best \_\_\_\_\_ at worst \_\_\_\_\_

## Please check all medical tests/visits that you have had within the past year

- Biopsy
- Blood tests
- Bone scan
- CT scan
- EMG (electromyogram)
- Chiropractic care
- Mammogram
- MRI
- Myelogram
- Nerve conduction velocity
- Stool test
- Pain doctor
- Stress test
- Urine test
- X-rays
- Urodynamics
- Counselor
- Other: \_\_\_\_\_

## Please check all previous procedures/surgeries

- Hysterectomy ⇨ Type:  abdominal or  vaginal  ovaries removed
- Hernia repair  C-section
- Appendectomy  Kidney surgery  Back/neck surgery  Colonoscopy  Endoscopy
- Gallbladder  Bladder surgery  Laparoscopic  Hydrodystension

## Please check all medical problems that you have now or have had in the past

- Low back pain/sciatica
- Shoulder/wrist/elbow pain
- Knee pain
- Leg cramps
- Fibromyalgia
- High blood pressure
- Pelvic inflammatory disease
- Heart/lung disease
- Osteoporosis
- Previous strokes
- Broken bones
- Neck/middle back pain
- Pelvic/vulvar pain
- Ankle/foot pain
- Carpal tunnel syndrome
- Chronic fatigue syndrome
- Diabetes
- Endometriosis
- Interstitial cystitis
- Cancer \_\_\_\_\_
- Epilepsy
- Unusual reaction to hot/cold
- Smoking ( \_\_\_\_\_ packs per day)
- Hip pain
- Rectal pain
- Pain with intercourse
- Arthritis
- Light-headedness
- Fibroids
- Kidney disease
- Migraines
- Head/chest/TMJ
- Respiratory problems
- STD's
- Bowel problems

Have you ever had physical therapy?  No  Yes Reason? \_\_\_\_\_

Have you had physical therapy this year?  No  Yes If so, how many visits? \_\_\_\_\_

Please list your usual recreational and exercise activities: \_\_\_\_\_

Occupation? \_\_\_\_\_  Full Time  Part Time Any Restrictions? \_\_\_\_\_

Married  Single  Widowed Please list current medications (prescription and non-prescription): \_\_\_\_\_

Hormone Replacement Therapy (HRT)?  No  Yes ⇨ If yes,  Pill  Patch  Cream  Estrogen  Progesterone

### **Sexual History**

Are you sexually active?  No  Yes Birth Control? \_\_\_\_\_ Any history of sexual abuse?  No  Yes

Do you have pain with tampon use?  No  Yes Do you have pain with intercourse?  No  Yes

### **Obstetric History**

How many children do you have? \_\_\_\_\_

If pregnant, what is your due date? \_\_\_\_\_ Number of weeks gestation? \_\_\_\_\_

Number of previous pregnancies? \_\_\_\_\_ Number of C-Sections? \_\_\_\_\_

Number of episiotomies? \_\_\_\_\_ Complications of this or other pregnancies? \_\_\_\_\_

### **Please check all bladder habits that apply**

- |   |  |
|---|--|
| <input type="checkbox"/> Frequent urinary tract infections                | <input type="checkbox"/> Difficulty initiating urine stream  |
| <input type="checkbox"/> Strong urge to urinate produces involuntary loss | <input type="checkbox"/> Difficulty stopping urination   |
| <input type="checkbox"/> Loss of urine on the way to bathroom             | <input type="checkbox"/> Urinary retention   |
| <input type="checkbox"/> Urgency when cold/hear running water             | <input type="checkbox"/> Burning with urination  |
| <input type="checkbox"/> Loss of urine upon arriving at bathroom          | <input type="checkbox"/> Loss of urine when coughing, sneezing, lifting, exercising, running, etc. |
| <input type="checkbox"/> Pain with urination                              | <input type="checkbox"/> Blood in urine  |

Voids/day \_\_\_\_\_ Voids/night \_\_\_\_\_ Voids/hour \_\_\_\_\_

Episodes of involuntary urine loss per day? \_\_\_\_\_ Amount lost?  few drips  small  continuous dribbling  large

Bed wetting?  No  Yes Do you use a protective pad?  No  Yes Number of pads per day? \_\_\_\_\_

Do you restrict your fluid intake because of urinary leakage?  No  Yes

How many cups of caffeinated coffee or carbonated beverages per day? \_\_\_\_\_

Number of cups of water per day? \_\_\_\_\_ Number of cups of juice per day? \_\_\_\_\_

Have you ever taken medication(s) to prevent urine loss?  No  Yes

### **Bowel History**

Do you have a gastrointestinal disease?  No  Yes

How do you resolve constipation?  High fiber diet  Laxatives  Enemas

Are you frequently constipated?  No  Yes

Do you frequently have diarrhea?  No  Yes

Do you notice blood in your stool?  No  Yes ⇨ If yes, how often? \_\_\_\_\_

Do you have hemorrhoids?  No  Yes

Do you have leakage of stool?  No  Yes

Do you have rectal pain?  No  Yes ⇨ If yes,  At rest  Sharp, fleeting pain  Only with bowel movement

### **Please rate how your pain/dysfunction interferes with your quality of life:**

Doesn't interfere    0    1    2    3    4    5    6    7    8    9    10    Disabling pain/dysfunction