WOMEN'S HEALTH QUESTIONNAIRE

Name: _________________________________ DOB: _____________ Appointment Date: _______________
Primary physician: _________________________ Referring physician: _______________________________

Describe the reason for today's appointment (your main complaint/problem):
____
____

What goals do you hope to accomplish with therapy? ____
____
____

When did the problem begin? ________________ Is it better, worse, or staying the same? _______________

Have you had any prior treatment for this problem? YES NO If yes, please describe? ________________
____

List activities or things that you cannot do because of this problem. How does the problem affect your life?
____
____

What are you currently doing to manage the problem? ____
____

MEDICAL HISTORY (Place a check mark next to any you have had or currently have):

__ Childhood Illnesses	__ Back Problems	__ Epilepsy	__ Arthritis
__ Heart Problems	__ High Blood Pressure	__ Stroke	__ Serious Injury
__ Lung Disease	__ Chronic Cough	__ Tuberculosis (TB)	__ Accident
__ Kidney Disease	__ Diabetes	__ Cancer	__ Glaucoma
__ Urinary Tract	__ Bowel Problems	__ Emotional Problems	__ Thyroid problems
__ Liver Disease	__ Seizure Disorder	__ Psychiatric Disorder	__ Neurologic Disease

__ Other (please list)____

ALLERGIES: Do you have any allergies? YES NO

If yes, please list what you are allergic to and the reaction you have had: _________________________
____
____

MEDICATIONS: Please list all of your present medications (include dosages & frequency taken)
____
____
____

SURGICAL HISTORY: Have you ever had any operations? YES NO

If yes, please list the TYPE of surgery, REASON for surgery, and DATE of surgery
____
____
____

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SOCIAL HISTORY:

Occupation: ______________________________________ Retired? YES NO

Current marital status: Single__ Married __ Widowed __ Divorced __ Are you sexually active? YES NO

Have you ever smoked tobacco? YES NO If yes, how much? ____________________________________

If yes, have you quit? YES NO

Do you drink alcohol? YES NO If yes, how much? ____

Do you use any street drugs? YES NO If yes, what? ____

HEALTH HABITS: (Please answer in space provided)

Do you see a doctor regularly for exams? ____

How many hours do you sleep at night? ____

Do you eat a well-rounded diet? ____

Do you exercise regularly? YES NO If yes, what type of exercise & how often? _____________________

____

Do you consider yourself to be healthy? YES NO

Do you have any physical limitations? YES NO If yes, explain: ___________________________________

____

GYNECOLOGIC HISTORY:

Number of pregnancies: ______ Age with first delivery? _____ Age with last delivery? _____

Number of vaginal deliveries: __________ Number of cesarean deliveries: __________

Forceps/Vacuum? YES NO Episiotomy/tears? YES NO

Problems during delivery? YES NO If yes, explain: ____

Did you experience incontinence during pregnancy? YES NO

Are your periods regular? YES NO Abnormally painful? YES NO

If painful, how do you cope? ____

Have you gone through menopause? YES NO If yes, at what age? _____

Reason for menopause: Natural? YES NO Due to hysterectomy? YES NO

Do you have a history of yeast infections? YES NO If yes, how often? ___________________________

Have you had any venereal diseases? YES NO If yes, what? ____________________________________

Any gynecologic problem(s) not already discussed? YES NO If yes, explain ______________________

____

EMOTIONAL HISTORY:

Does emotional stress affect symptoms? YES NO

Have you ever been diagnosed with and/or treated for a nervous condition? YES NO

Have you ever been diagnosed with and/or treated for depression? YES NO

Have you ever experienced domestic violence? YES NO

Have you ever experienced rape? YES NO Date rape? YES NO

Have you ever experienced sexual abuse/molestation? YES NO

Have you ever experienced incest? YES NO

SYMPTOM SEVERITY:

On a scale of 0-10 with 10 being the most severe, what is the current severity of your problem?

0 1 2 3 4 5 6 7 8 9 10

With 0 being not true at all to 10 being true, rate the following statement as it applies to you today:

My problem is controlling my life

0 1 2 3 4 5 6 7 8 9 10

PLEASE COMPLETE THE FOLLOWING SECTIONS THAT ARE APPLICABLE TO YOUR PROBLEM.

FOR ANY PAIN QUESTIONS, PLEASE REFER TO THIS MANKOSKI PAIN SCALE:

0 - Pain Free
1 - Very minor annoyance with occasional minor twinges. No medication needed.
2 - Minor annoyance with occasional strong twinges. No medication needed.
3 - Annoying enough to be distracting. Mild painkillers (such as aspirin or ibuprofen) take care of it.
4 - Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.
5 - Can't be ignored for more than 30 minutes. Mild painkillers make the pain better or more tolerable for 3-4 hours.
6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (such as codeine or narcotics) reduce pain for 3-4 hours.
7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.
8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.
10 - Unconscious. Pain makes you pass out.

SECTION A: PELVIC PAIN

Do you experience pelvic pain? YES NO (If no, skip to Section B)
If yes, give a description and location of the pain ____
____
Do you experience pain with intercourse? YES NO
If yes, which of the following cause pain and indicate the severity:
__ Initial penetration - pain rating _____/10
__ Thrusting - pain rating _____/10
__ Orgasm - pain rating _____/10
Does the pain continue after intercourse? YES NO If yes, pain rating _____/10
How long does the pain last? _____hours or _____days
Mark any of the following events that cause pain and rate the severity:
__ During pelvic exam - pain rating _____/10
__ Insertion of tampons - pain rating _____/10
__ Sitting - pain rating _____/10
__ Certain clothing - pain rating _____/10
__ Other (describe) ____ - pain rating _____/10
What activities are limited by your pain? ____
What makes the pain worse? ____
What makes the pain better? ____
How long have you had this pelvic pain? ____
Any event (such as accident, surgery, childbirth) associated with the onset of your pelvic pain symptoms? YES NO If yes, explain ____
____

SECTION B: VOIDING HABITS

Did you have difficulty holding urine as a child? YES NO
As a child, did you wet the bed beyond the age of 5? YES NO
Have you been treated for more than two urinary tract infections this year? YES NO
When was the last time you had a urinary tract infection? ______________________________________
Is your urine ever bloody? YES NO
Have you ever been treated with urethral dilatation? YES NO
If yes, how many times? __________________________ Did it help? YES NO
Do you feel that you urinate too often? YES NO
Do you usually get up to urinate during the sleeping hours? YES NO
If yes, how many times? __________________________
How many times during the day do you urinate? __ 1-4 __5-8 __9-12 __more than 12
How often do you pass urine during the day? Every ____ hours
Is the volume of urine you usually pass __ very small __ small __ average __ large
Do you restrict your fluid intake because of your problem? YES NO
Do you constantly feel an urge to urinate? YES NO
Do you often experience a strong, sudden urge to urinate? YES NO
Do you often feel you must rush to the toilet? YES NO
If yes, does it occur: __ all of the time __most of the time __ half the time __ some of the time
How long can you hold back the urge to urinate? ____
Do you lose urine when you have the urge to urinate? YES NO
If yes, does it occur: __ all of the time __most of the time __ half the time __ some of the time
Do you experience a strong sense of urgency with any of the following:
Temperature changes? YES NO Running water? YES NO
Entering the house? YES NO Approaching the toilet? YES NO
Other? YES NO If yes, describe ____
Do you sometimes feel you need to urinate again immediately after urinating? YES NO
Do you void before leaving the house "just in case" ? YES NO
Are you conscious of where the nearest toilet is when you are away from home? YES NO
Do you have difficulty emptying your bladder completely? YES NO
If yes, does it occur: __ all of the time __most of the time __ half the time __ some of the time
How do you manage this problem? ____
Is the urine stream ever hesitant or interrupted? YES NO
If yes, does it occur: __ all of the time __most of the time __ half the time __ some of the time
Do you need to strain to empty? YES NO
If yes, does it occur: __ all of the time __most of the time __ half the time __ some of the time
Do you have difficulty telling when your bladder is full? YES NO
Do you dribble just after urinating (such as when you stand up)? YES NO
If yes, does it occur: __ all of the time __most of the time __ half the time __ some of the time
Do you have trouble stopping your urine midstream? YES NO

SECTION C: URINARY INCONTINENCE

Do you experience uncontrollable loss of urine? YES NO (If no, skip to Section D)
Do you lose urine with any of the following events:
Coughing? YES NO Sneezing? YES NO Lifting objects? YES NO
Straining? YES NO Bending? YES NO Walking? YES NO
During intercourse? YES NO After intercourse? YES NO
Is the volume you lose: __ a few drops __ wet underwear or pad __ soaked pad or clothing
Do you lose urine with a strong urge that cannot be controlled? YES NO
If yes, does it occur __ all of the time __most of the time __ half the time __some of the time

SECTION C: URINARY INCONTINENCE (continued)

In which positions does urine loss usually occur?

__ lying down __ sitting __ standing __ moving from sitting to standing position

Is your loss of urine a continual drip so that you feel constantly wet? YES NO

Do you ever lose urine without any warning or urge? YES NO

If yes, please explain when/how: ____

Do you lose urine without feeling it happen? YES NO

Do you lose urine while you sleep? YES NO

Do you wear protection for urine loss? YES NO

If yes, what type? ______________________ How many per day?______________

Do you experience hygiene or skin problems related to your leakage? YES NO

SECTION D: BLADDER PAIN

Do you have discomfort associated with your bladder? YES NO (If no, skip to Section E)

If yes, location/description of pain: ____

Mark the events that cause pain and rate the severity:

__ With bladder fullness - pain rating _____/10

__ During voiding - pain rating _____/10

__ After voiding - pain rating _____/10

__ Other (describe) ____ - pain rating _____/10

What activities are limited by your pain? ____

What makes the pain worse? ____

What makes the pain better? ____

How long have you had this bladder pain? ____

Any event (such as accident, surgery, childbirth) associated with the onset of your bladder pain symptoms? YES NO If yes, explain ____

____

SECTION E: BOWEL HABITS

How often do you have a bowel movement? ____

Do you ever attempt evacuation without results? YES NO If yes, how often? _________________

Do you use any of the following to help you evacuate? (Mark all that apply)

__ Laxatives (type: ________________) __ Suppository

__ Enema __ Manual removal __ Fiber supplement

__ Other (describe) ____

What is your typical stool consistency:

__ Separate hard lumps, like nuts __ Like a sausage or snake but with cracks on surface

__ Sausage shaped but lumpy __ Like a sausage or snake but smooth and soft

__ Soft blobs with clear cut edges __ Fluffy pieces with ragged edges or mushy stool

__ Watery, no solid pieces __ Combination of all options

Do you ever experience blood in the stool or on the tissue? YES NO

Do you experience a sensation of the need to evacuate? YES NO

If yes, rate the sensation: __ normal __ blunted/uncertain __ strong/urgent

Do you constantly feel an urge to evacuate? YES NO

Do you lose stool with a strong urge that cannot be controlled? YES NO

If yes, does it occur __ all of the time __most of the time __ half the time __some of the time

How long can you hold the urge to evacuate? _______________________________________

Do you have a problem with constipation? YES NO

SECTION E: BOWEL HABITS (continued)

Do you strain to pass stool? YES NO

If yes, does it occur __ all of the time __most of the time __ half the time __some of the time

On average, how much time do you spend on the toilet for each evacuation? _______________

Do you have difficulty emptying your bowels completely? YES NO

If yes, does it occur __ all of the time __most of the time __ half the time __some of the time

Do you feel stool remains: __ at the anal opening or __ higher in the rectum/colon

Do you have difficulty with hygiene after a bowel movement? YES NO

Are you unable to feel the difference between solid stool, liquid stool, and gas? YES NO

SECTION F: BOWEL INCONTINENCE

Are you unable to avoid passing gas in public? YES NO

Do you experience uncontrollable loss of stool or stool seepage? YES NO (If no, skip to Section G)

Do you lose stool with any of the following events?

Coughing? YES NO Sneezing? YES NO Lifting? YES NO

Straining? YES NO Releasing gas? YES NO Urinating? YES NO

Aerobic exercise? YES NO Intercourse? YES NO

Is the amount you lose:

__ Stain/smear __ 2 Tbsp or less __ ¼ to ½ cup __ ½ to 1 cup __ greater than 1 cup

What is the consistency of the stool you lose?

__ formed/solid __ hard balls __loose/unformed __ liquid/mucous

How often does this happen? ____

Do you lose stool with a strong urge that cannot be controlled? YES NO

If yes, does it occur __ all of the time __most of the time __ half the time __some of the time

Do you ever lose stool without any warning or urge? YES NO

If yes, explain when and how? ____

Do you lose stool without feeling it happen? YES NO

If yes, explain when and how? ____

Does the stool loss, seepage or staining occur after a bowel movement? YES NO

Does the stool loss, seepage or staining occur during sleep? YES NO

Do you wear protection for stool loss? YES NO

If yes, what type? ________________________ How many per day?_______________

SECTION G: BOWEL/ABDOMINAL PAIN

Do you experience pain related to bowel function? YES NO (If no, you have completed this form!)

If yes, location/description of pain ____

Mark the following events that cause pain and rate the severity:

__ Before bowel movement - pain rating _____/10

__ During bowel movement - pain rating _____/10

__ After bowel movement - pain rating _____/10

__ With meals - pain rating _____/10

__ Other (describe) ____ - pain rating _____/10

What activities are limited by your pain? ____

What makes the pain worse? ____

What makes the pain better? ____

How long have you had this bowel/abdominal pain? ___________________________________

Any event (such as accident, surgery, childbirth) associated with the onset of your bowel/abdominal pain symptoms? YES NO If yes, explain ____

____