MCHHS
MITCHELL COUNTY HOSPITAL
• HEALTH SYSTEMS •

Date: _____

Patient History

1. Describe the current problem that brought you here? _____
_____
2. When did your problem first begin? ____ months ago or ____ years ago
3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____
4. Since that time is it: ▢ staying the same ▢ getting worse ▢ getting better
Why or how? _____
5. If pain is present, rate pain on a 0-10 scale (10 being the worst) ___/10
Describe the nature of the pain (i.e. constant burning, intermittent ache) _____
_____
6. Describe previous treatment/exercises _____
_____
7. Activities/events that cause or aggravate your symptoms. Check all that apply

- ▢ Sitting greater than _____ minutes
- ▢ Walking greater than _____ minutes
- ▢ Standing greater than _____ minutes
- ▢ Changing positions (i.e. sit to stand)
- ▢ Light activity (light housework)
- ▢ Vigorous activity/exercise (run/weight lift/jump)
- ▢ Sexual activity
- ▢ Other, please list _____
- ▢ With cough/sneeze/straining
- ▢ With laughing/yelling
- ▢ With lifting/bending
- ▢ With cold weather
- ▢ With triggers-running water/key in door
- ▢ With nervousness/anxiety
- ▢ No activity affects this problem

8. What relieves your symptoms? _____
_____
9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (excludes physical activities), specify _____
Diet/Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____
10. Rate the severity of this problem from 0-10 (0 no problem at all, 10 being the worst) ___/10
11. What are your treatment goals/concerns?_____
_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night sweats/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness/Tingling

Y/N Other, describe _____
_____

Health History

Date of last physical exam _____
Tests performed _____
General Health ▢ Excellent ▢ Good ▢ Average ▢ Fair ▢ Poor
Occupation _____ Hours/week _____
On disability or leave? _____ Activity restrictions? _____

Mental Health Current level of stress ▢ High ▢ Medium ▢ Low Current psych therapy? Y/N
Activity/Exercise ▢ None ▢ 1-2 days/week ▢ 3-4 days/week ▢ 5+ days/week
Describe _____

Have you ever had any of the following conditions or diagnoses? Mark all that apply, describe below

▢ Cancer	▢ Stroke	▢ Emphysema/chronic bronchitis
▢ Heart problems	▢ Epilepsy/seizures	▢ Asthma
▢ High Blood Pressure	▢ Multiple sclerosis	▢ Allergies- list below
▢ Ankle swelling	▢ Head Injury	▢ Latex sensitivity
▢ Anemia	▢ Osteoporosis	▢ Hypothyroid/Hyperthyroid
▢ Low back pain	▢ Chronic Fatigue Syndrome	▢ Headaches
▢ Sacroiliac/Tailbone pain	▢ Fibromyalgia	▢ Diabetes
▢ Alcoholism/Drug problem	▢ Arthritic conditions	▢ Kidney disease
▢ Childhood bladder problems	▢ Stress fracture	▢ Irritable Bowel Syndrome
▢ Depression	▢ Rheumatoid Arthritis	▢ Hepatitis
▢ Anorexia/bulimia	▢ Joint Replacement	▢ Sexually transmitted disease
▢ Smoking history	▢ Bone fracture	▢ Physical or Sexual abuse
▢ Vision/eye problems	▢ Sports Injuries	▢ Raynaud's (cold hands and feet)
▢ Hearing loss/problems	▢ TMJ/neck pain	▢ Pelvic pain
▢ HIV/AIDS	▢ Other/Describe _____	

Surgical/Procedure History

Y/N Surgery for your back /spine	Y/N	Surgery for your bladder/prostate
Y/N Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/Describe _____

OB/GYN History (females only)

Y/N Childbirth vaginal deliveries # _____	Y/N	Vaginal dryness
Y/N Episiotomy # _____	Y/N	Painful periods
Y/N C-Section # _____	Y/N	Menopause- When? _____
Y/N Difficult childbirth # _____	Y/N	Painful vaginal penetration
Y/N Prolapse or organ falling out	Y/N	Pelvic pain

Other/Describe _____

Males only

Y/N Prostate disorders	Y/N	Erectile dysfunction
Y/N Shy bladder	Y/N	Painful ejaculation
Y/N Pelvic pain		

Other/Describe _____

Pelvic Symptom Questionnaire

Bladder/Bowel Habits/Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent/slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections

Other/Describe _____

1. Frequency of urination: awake hours _____ times per day sleeping hours _____ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   _____ minutes, _____hours, _____not at all
3. The usual amount of urine passed is ▢ small ▢ medium ▢ large
4. Frequency of bowel movements _____times per day, _____ times per week, or _____
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____ minutes, _____hours, _____not at all
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day
   Of this total how many glasses are caffeinated _____ glasses per day
8. Rate a feeling of organ “falling out”/prolapse or pelvic heaviness/pressure

▢ None present
▢ _____ Times per month (specify if related to activity or your period)
▢ With standing for _____ minutes or _____hours
▢ With exertion or straining
▢ Other _____

Skip questions if no leakage/incontinence

9a. Bladder leakage- number of episodes
_____ No leakage
_____ Times per day
_____ Times per week
_____ Times per month
_____ Only with physical exertion/cough

9b. Bowel leakage- number of episodes
_____ No leakage
_____ Times per day
_____ Times per week
_____ Times per month
_____ Only with physical exertion/cough

10a. On average, how much urine do you leak?
_____ No leakage
_____ Just a few drops
_____ Wets underwear
_____ Wets outerwear
_____ Wests the floor

10b. How much stool do you lose?
_____ No leakage
_____ Stool staining
_____ Small amount in underwear
_____ Complete emptying

11. What form of protection do you wear? (Please complete only one)

▢ None
▢ Minimal protection (tissue paper/paper towel/pantishields)
▢ Moderate protection (absorbent product, maxipad)
▢ Maximum protection (specialty product/diaper)
▢ Other _____

On average how many pad/protection changes are required in 24 hours? ____# of changes

Medications

Medications- pills, injection, patch Start date Reason for taking

Over the counter- vitamins etc Start date Reason for taking