



Centreville Physical Therapy, P.C.

14631 Lee Highway, Suite 310

Centreville, VA 20120

Ph: (703) 222-5903 Fax: (703) 222-3765

Patient Name _____

MEDICAL HISTORY

Date of Birth: ____/____/____ Gender: M Right-handed
 F Left-handed

Please check if you have ever had:

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Arthritis (Osteoarthritis or Rheumatoid Arthritis) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Breathing / Lung Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Diabetes / High Blood Sugar | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Other: _____ |

Please check if you have experienced the following symptoms in the past year:

- | | |
|---|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Loss of balance or falls | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Fever / Chills / Sweats |
| <input type="checkbox"/> Difficulty dressing | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Difficulty lifting | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Weakness in arms or legs | |

Have you ever had surgery? Yes No If yes, please describe and provide date:

Date: ____/____/____

Date: ____/____/____

Date: ____/____/____

Do you take any prescription or non-prescription medications? Yes No If yes, please list below:

Do you: Smoke ____ppd Drink alcohol ____drinks/week
 Exercise ____times/week for ____minutes

Are you currently pregnant? Yes No

MALE INCONTINENCE QUESTIONNAIRE

| Name | D.O.B. | | | |
|--|--------|--|--|------|
| Date | | | | |
| 1. Are you able to void at the toilet? | | | | |
| 2. Is the urge to void present? | | | | |
| 3. Is there pain or burning when you void? | | | | |
| 4. Is it difficult to start your urine flow? | | | | |
| 5. Do you have a weak stream? | | | | |
| 6. Do you lose urine when you: | | | | |
| a. Have a strong urge? | | | | |
| b. See, hear or feel water? | | | | |
| c. Move from sit to stand? | | | | |
| d. Lift heavy objects? | | | | |
| e. Sneeze, cough or laugh? | | | | |
| f. Walk, run or exercise? | | | | |
| g. Sleep? | | | | |
| h. Other? | | | | |
| 7. Do you experience dribbling after voiding? | | | | |
| 8. How many pads/diapers each day? | | | | |
| 9. Are your pads thick or thin? | | | | |
| 10. Are they damp, wet or soaked when changed? | | | | |
| 11. How many times do you get up at night to void? | | | | |
| 12. How many pads do you wear through the night? | | | | |
| 13. Are they damp, wet or soaked when changed? | | | | |
| 14. # Risk factors | | | | |
| Total Score | | | | |
| Bladder Diary Findings | | | | |
| Void interval | | | | |
| Void volume | | | | |
| Bladder irritants | | | | |
| Bowel habits | | | | |
| Clinician Signature | | | | Date |
| Clinician Signature | | | | Date |
| Clinician Signature | | | | Date |
| Clinician Signature | | | | Date |