



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

Please complete this form and bring it in with you on your first visit.

If you experience: Incontinence/Pelvic Floor Muscle Weakness/Prolapse: Answer all the Following Questions. If you are experiencing pelvic pain, please proceed to section II and III.

Section I:

Do you experience a:

Loss of urine with cough, laugh, or sneeze?	Yes	no
Loss of urine when lifting	yes	no
Loss of urine with exercise, running, etc.?	yes	no
Loss of urine when you have a strong urge to urinate?	Yes	no
Loss of urine on the way to the bathroom?	Yes	no
Loss of urine when removing clothing to urinate?	Yes	no

Do you :

Experience an urge to urinate when you hear running water	yes	no
And the are unable to get to the toilet	yes	no

Have difficulty initiating a urine stream?	Yes	no
Have pain with urination?	Yes	no
Have burning with urination?	Yes	no
Have blood in your urine?	Yes	no
Have to strain to empty your bladder	yes	no
Dribble urine when you urinate?	Yes	no
Dribble after you empty your bladder	yes	no

When you have an uncontrolled loss of urine:

Is it usually a small amount	yes	no
Is it usually a large amount	yes	no

Voiding patterns:

Voiding frequency _____/times per day	#of times per night _____
Incontinence: # of episodes per day _____	# of episodes at night _____
Amount of urine loss _____large _____small _____few drops	

Protective Devices: What type of protective devices do you use? Circle all that apply

_____ panty liner, sanitary pad(mini), sanitary maxi pad, incontinence pad, incontinence brief,
Other _____

#of pads used per day _____

Do you soak the pad fully: yes no

Do you change the pad each time it is wet? Yes no

Daily fluid intake:

of cups of water per day _____

of cups that contain caffeine/carbonation/acid _____

Do you restrict fluids due to incontinence yes no

Signature: _____

Name: _____

Bowel habits:

How often do you have a bowel movement _____
Are you ever constipated? Yes no, How do you resolve this _____
Do you experience diarrhea yes no
Do you use laxatives yes no How often _____
Do you use enemas yes no How often _____
Do you include fiber in your diet yes no Describe _____

Section II: For all pain patients

Describe your pain _____ Where is your pain? _____
Do you experience burning pain yes no
Do you experience numbness/tingling yes no Where? _____
Do you have pain with urination/BM? Yes no
Do you have pain with intercourse yes no
Do you experience Lower Back pain yes no How often _____
What aggravates your pain? _____
What relieves your pain? _____

On scale of 0-10, what level is your pain? _____/10, at its best _____/10 at its worst _____/10
Do you limit recreational or daily activities because of pain? Yes no
Does your pain affect your sleeping pattern? Yes no

Section III: All Patients

Mobility/Self care:

Do you use(circle any that apply): cane, walker, lean on furniture for balance
Do you have difficulty(circle all that apply): getting on/off toilet, getting clothes on/off, with toilet hygiene

Psychosocial status:

Living arrangements: do you live alone? Yes no
Occupation: _____
Recreational Activities: _____
Do you restrict any activities due to urinary incontinence? Yes no

What are your feelings about your urinary incontinence on a scale of 1-10.

No impairment 0 1 2 3 4 5 6 7 8 9 10 severe impairment
Have you had changes in intimate relationships/sexual function due to urinary incontinence? Yes no
Have you had changes in intimate relationships/sexual function due to pelvic pain? Yes no

Signature _____

Date: _____