



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

### WOMEN'S HEALTH INCONTINENCE SCREENING QUESTIONNAIRE

Date of last doctor's visit: \_\_\_\_\_

Last pelvic exam: \_\_\_\_\_ Last urinalysis: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had previous tests for the condition for which you are coming for Physical Therapy?  Yes  No

If yes, please list tests: \_\_\_\_\_

Do you now have or have you had a history of the following? Explain yes response(s) and include dates:

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder infections              | <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pelvic Pain                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Broken bones                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Low back pain/sciatica          | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes                        | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/Bronchitis             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis              | <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually transmitted diseases    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies                       | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS                         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Fecal incontinence               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Childhood bladder problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking habit                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Trouble holding back gas        | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in urine                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Trouble initiating urine stream | <input type="checkbox"/> Yes <input type="checkbox"/> No Trouble feeling bladder fullness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal dryness                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder cancer                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Trouble emptying bladder        | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex allergy                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Constant dribbling of urine     | <input type="checkbox"/> Yes <input type="checkbox"/> No Other (please list)              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation                    |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint problems                  |   |

Explanation of the above responses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parkview Adventist Medical Center  
329 Maine St., Brunswick, ME 04011

RSD214-0407 (08-03-07)

PATIENT IDENTIFICATION



R S D 2 1 4

THIS FORM IS A MEDICAL RECORD

## WOMEN'S HEALTH INCONTINENCE SCREENING QUESTIONNAIRE

### Surgical History

- |                              |                             |                                    |                              |                             |                               |
|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgery for your back/spine?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgery for your bladder?     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgery for your brain?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgery for abdominal organs? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgery for your female organs?    |                              |                             |                               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other type, please describe: _____ |                              |                             |                               |

### OB/GYN History

- |                              |                              |                                 |                              |                             |                      |
|------------------------------|------------------------------|---------------------------------|------------------------------|-----------------------------|----------------------|
| Date of last period: _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No     | Menopause                    |                             |                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No  | Painful periods                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | C-Section # _____    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No  | Painful penetration             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Episiotomy # _____   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No  | Vaginal deliveries # _____      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Difficult childbirth |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No  | Prolapse or falling out feeling |                              |                             |                      |

Explain yes responses:

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Medications	Start Date	Reasons for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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