CLEAR FORM

TRIANGLE PHYSIOTHERAPY & REHABILITATION

www.trianglephysiotherapy.com

FEMALE PELVIC HEALTH SUBJECTIVE HISTORY FORM

PATIENT INFORMATION

Last Name:	First Name:	
Date of Birth:		
Apt/Suite/Unit No:	Street:	
City:	Postal Code:	
Home Tel. #:	Work Tel. #:	Cell #:
E-mail:		Occupation:
Referring Physician:	Telephone:	
Sports/Hobbies:		
Relative Activity Level ☐ Sedentary ☐ Active		Reason for consultation:
Pertinent reports:		Medical diagnosis:
Symptoms:		Change in symptoms:

HOW DID YOU HEAR ABOUT US? (MARK ALL THAT APPLY)

☐ I have been here before ☐ Doctor's Referral ☐ Yellow Pages Book ☐ yp.ca ☐ Google search ☐ Friend/Family/Co-Worker (please name)
☐ Sign Board ☐ Just Walked In ☐ Flyer ☐ VennGo ☐ Other: _____

MEDICAL HISTORY

Surgery: ☐ Y ☐ N	Incision site:
Any history of cancer: ☐ Y ☐ N	Medication:
Weight: Height:	Allergies: ☐ Yes ☐ No
Vinyl: ☐ Yes ☐ No	
Menses: ☐ Yes ☐ No	Regular: ☐ Yes ☐ No
Menopause: ☐ Yes ☐ No	Symptoms worsen during menses: ☐ Yes ☐ No
Urinary Tract infection: ☐ Yes ☐ No If Yes, how often:	
Alcohol: ☐ Yes ☐ No /week	Smoking: ☐ Yes ☐ No /day
Water intake in ml per day:	
Heaviness in Pelvic Region: ☐ Yes ☐ No	Bulging/Protrusion in vaginal area: ☐ Yes ☐ No
Pain during urination: ☐ Yes ☐ No	Pain in lower abdominal area: ☐ Yes ☐ No
Pain in genital area: ☐ Yes ☐ No	Sexually active: ☐ Yes ☐ No
Incontinence during intercourse: ☐ Yes ☐ No	Fecal incontinence: ☐ Yes ☐ No
Bowel movement: /day or week	Stool consistency:
Evacuation difficulties/straining: ☐ Yes ☐ No	Hemorrhoids: ☐ Yes ☐ No
Circumstance of urinary leakage: ☐ Laugh ☐ Cough ☐ Walk ☐ Run ☐ Exercise ☐ Lift ☐ Other	
Frequency of Leakage: ☐ Daily ☐ Nightly ☐ Continuous ☐ Episodic	
Urination frequency: Daily Nightly	Urge incontinence: ☐ Never ☐ Every time ☐ Occasional ☐ Rare
Urgency with: ☐ Stress ☐ Water ☐ Cold ☐ Key in door ☐ Other	
Urine flow: ☐ Weak ☐ Normal	Hard to begin: ☐ Yes ☐ No

Dribbling: ☐ Yes ☐ No	Feel Bladder still full: ☐ Yes ☐ No	Protective padding: ☐ Yes ☐ No
Description of wetness: ☐ Not wet ☐ Slightly wet ☐ Very wet ☐ Soaked		
Number of pregnancies:	Number of Births:	Age of Children:
Symptoms before pregnancy: ☐ Yes ☐ No	Symptoms after pregnancy: ☐ Yes ☐ No	
Weight of heaviest baby:	☐ C-section ☐ Induced ☐ Epidural ☐ Breach ☐ Forceps ☐ Suction ☐Episiotomy	
Tearing grade:	Prolonged second stage:	Currently nursing: ☐ Yes ☐ No

Signature of Patient **Date:**