CLEAR FORM

FEMALE SYMPTOM MONITOR

Name: _____ Date: _____

Occupation: _____ Age: _____

Complaints: 1. _____

2. _____

3. _____

GYNECOLOGICAL HISTORY:

pregnancies: ___ # live births: ___ Wt. heaviest baby: ___ lbs ___ oz Length pushing stage: ___ hours

Forceps? ☐ Yes ☐ No Episiotomies? ☐ Yes ☐ No Tears? ☐ Yes ☐ No

HRT? ☐ Yes ☐ No When? _____ Last pap: _____ Normal? ☐ Yes ☐ No

Sexually Active? ☐ Yes ☐ No Pain with sex? ☐ Yes ☐ No When? ☐ Penetration ☐ Thrusting?

Birth Control Method: _____ C-Section: ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No If yes, ☐ Trouble falling to sleep? ☐ Trouble Staying Asleep?

Do you have feelings of heaviness or pressure in your vagina? ☐ Yes ☐ No

Has anyone every told you that you have a prolapse? ☐ Yes ☐ No

SURGICAL HISTORY:

Abdominal: ☐ When: _____

Pelvic: ☐ When: _____

BLADDER SYMPTOMS: Please put an X next to the statements that best describe your symptoms:

My incontinence is associated with activities such as sneezing, running or laughing ☐ daily ☐ weekly

S

My leakage occurs after having a strong voiding sensation that feels uncontrollable ☐ daily ☐ weekly

U

I void during the day more than the average person (>5-7 X/day) _____ # times per day

F

My bladder troubles cause me to go to the bathroom at night _____ # times/night

N

My bladder problems cause me to leak at night _____ # times/week

N

My incontinence requires me to wear pads _____ # pads/day

When I void I don't empty completely and feel like I have to go again soon ☐ Yes ☐ No ☐ Sometimes

R

I have pain when I urinate ☐ Yes ☐ No ☐ Sometimes

PBS

I have to strain when I urinate ☐ Yes ☐ No ☐ Sometimes

TP

I have leakage during intercourse ☐ Yes ☐ No ☐ Sometimes

S

I had problems with my bladder during my childhood ☐ Yes ☐ No

I feel overwhelmingly strong sensations prior to voiding but I don't leak ☐ Yes ☐ No

U

Fluid Intake in 24 hours:

#____cups of coffee/day #____cups of water/day #____cups of tea/day # _____ cups of other fluids/day

BOWEL HISTORY:

Frequency: /week

Fecal Incontinence: ☐ Yes ☐ No Stool Consistency: ☐ Loose ☐ Soft/formed ☐ Hard ☐ Varies

Fecal Urgency: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

MEDICAL HISTORY:

Urinary Tract Infections: ☐ Yes ☐ No Antibiotics Recently? ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No ____ #packs/day

Chronic Cough: ☐ Yes ☐ No

Do you get blood in your urine: ☐ Yes ☐ No

Allergies (including latex): _____

Height: ____ ft. ____ In. Weight: _____ lbs BMI: _____(therapist)

Back Problems: ☐ Yes ☐ No

If yes, please ask the receptionist for the Pelvic Girdle Assessment Form

Neck Problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

On a scale from 1-10, please and rate your current pain/discomfort

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10