women's & men's health PHYSIOTHERAPY

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GENERAL HISTORY – FEMALE

Please complete the following questions (where relevant) regarding your medical and surgical history. All information is strictly confidential and will be further discussed at your appointment. Please bring this and any other forms included in your initial information package to your first consultation.

Name: _____ **Age:** _____

Height: _____ **Weight:** _____

OBSTETRIC:

If relevant, please complete details for all deliveries:
Number of pregnancies: ……..

Date	Vaginal or Caesarean	Weight	Forceps (Y/N)	Episiotomy/ tear	Length of pushing stage	Other

HORMONAL STATUS: Are you currently?

Pregnant	☐ Yes	☐ No	Weeks:
Breastfeeding	☐ Yes	☐ No	
Menstruating regularly	☐ Yes	☐ No	
Menopausal	☐ Yes	☐ No	
Post-menopausal	☐ Yes	☐ No	Age at end of menopause:

PAST SURGICAL HISTORY: (Please record date and surgeon)

1. Bladder surgery (e.g. colposuspension / sling etc):
   ……
   ……
   ……
2. Gynaecological surgery (e.g. hysterectomy / prolapse repair):
   ……
   ……
   ……
3. Bowel surgery:
   ……
   ……

4. Kidney surgery:
……
5. Back surgery:
……
6. Other Surgery:
……

MEDICAL and HEALTH ISSUES: (Past and / or current please tick one or more)

☐Diabetes	☐Lung disease/condition	☐Hernia
☐Heart Disease/condition	☐Arthritis	☐Osteoporosis
☐High blood pressure	☐Back problems	☐Depression/Anxiety
☐Neurological disease	☐Constipation/straining	☐Psychiatric illness
☐Stroke	☐Heavy lifting	☐Other (please specify)
☐Chronic cough/ Asthma	☐Prolonged standing	

Smoking status:

☐Non smoker ☐Past ☐Current No. of cigarettes per day ____

Have you been hospitalised in the past year? ☐Yes ☐No
If yes, please specify reasons and for how long?

MEDICATIONS*:*
Please list details of your current medications (including hormone replacement therapy, vitamins, or any product you take for bladder/bowel).

Medication	Dosage	Date commenced

PREVIOUS INVESTIGATION OR MANAGEMENT OF BLADDER, BOWEL OR PELVIC PROBLEMS:

☐ Nil ☐ Specialist referral ☐ Surgery (record details on page 1)

☐Investigations: (please specify results if known eg: bladder or bowel tests, scans etc)

☐ Physiotherapy If yes:
☐ Group / class ☐ Verbal instruction ☐ Individual assessment

Other conservative therapy: if yes, please specify ……

GENERAL:

Fluid intake: Please list your usual fluid intake (in no. of cups / glasses) over a 24 hour period

Water	Tea	Coffee	Alcohol	Milk	Juice	Soft Drink	Other

GENERAL EXERCISE:

Are you currently participating in any exercise? ☐Yes ☐No

If no, please list what exercise appeals to you and what you would like to do if you could:

……

If yes**,** please list your current level of exercise participation, using the numeric scale of "**Perceived Exertion**" as described here:

Rating and verbal description of your exertion:

6 7 8 9 10 11 12 13 14 15 16 17 18
Very very light, very light, fairly light, somewhat hard, hard, very hard, very, very hard

Type: Describe your exercise type below.	**Duration** e.g. 2 hrs; 30 mins	**Perceived Exertion** (numeric scale)	**Frequency** e.g. 1 x per week; 3 x per week

Thank you very much for completing this form, we look forward to discussing your responses further at our initial consultation and assisting you in improving your symptoms.