Evergreen Physical Therapy Specialists, PC

Women's Health Survey

EPTS Client: In order to gain a thorough understanding of your medical history and chief complaint(s), please, provide us with the following background information. If you have questions about specific items, leave them blank and ask your therapist for clarification or assistance.

NAME:_____ **DATE:**_____
OCCUPATION:_____
LEISURE ACTIVITIES:_____
Date of Birth_____
Please, check (X) any of the following health care providers whose care you are under:

_____Medical doctor (MD) _____Uro-gynecologist
_____Osteopath _____Physical Therapist
_____OB/GYN MD _____Chiropractor
_____Psychiatrist/Psychologist _____Other

Please, provide names of those caregivers:_____
Have you seen any of those providers in the past 3 months? Yes No
Please, describe for what reason:

Have you or your family **EVER** been diagnosed with having the following conditions:

Cancer	Yes	No		Family History	Yes	No	
If yes, describe what type:_____							
Date of Dx:_____							
Treatment(s):_____							
Heart Disease	Yes	No	Family(x)	High Blood Pressure	Yes	No	Family(x)
Circulation Problems	Yes	No		Asthma	Yes	No	
Emphysema/Bronchitis	Yes	No		Osteoporosis/Osteopenia	Yes	No	
Chemical Dependency or Alcoholism					Yes	No	
Thyroid Problems	Yes	No		Diabetes	Yes	No	
Multiple sclerosis	Yes	No		Rheumatoid arthritis	Yes	No	
Other arthritic conditions	Yes	No		Depression	Yes	No	
Hepatitis	Yes	No		Tuberculosis	Yes	No	
Stroke	Yes	No		Kidney Disease	Yes	No	
Anemia	Yes	No		Epilepsy/seizures	Yes	No	

Other_____

During the past month have you been feeling down, depressed or hopeless? Yes No
During the past month have you been bothered by having little interest or pleasure in doing things? Yes No
Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in any way? Yes No

ALLERGIES

List any allergies you have including medication allergies:_____
Are you latex sensitive? Yes No

SOCIAL HABITS

Do you smoke? Yes No _____packs per day
Do you drink Alcohol Yes No _____drinks/day or _____drinks/week
Do you drink coffee or other caffeinated beverages? Yes No ____/day

GYNECOLOGIC HISTORY

Menopause	Yes	No			
If No, last Menstrual Date:_____			Painful Periods	Yes	No
Endometriosis	Yes	No	Painful Intercourse	Yes	No
Pelvic Pain	Yes	No	Fibroids	Yes	No
Prolapse	Yes	No	Pelvic Inflammatory Disease	Yes	No
Cysts	Yes	No	Urinary Tract Infection(s)	Yes	No
Surgical Interventions:					
Abdominal Surgery	Yes	No	Hernia repair	Yes	No
Appendix	Yes	No	Gall Bladder	Yes	No
Laparoscopy	Yes	No	Hemorrhoids	Yes	No
Bladder Suspension	Yes	No	Hysterectomy	Yes	No
Vaginal Repair	Yes	No	Other_____		

OBSTETRIC History

Number of pregnancies____ Number of Deliveries_____ Are you pregnant? Yes No Week #_____

Date of Delivery	Type of Delivery	Weight of Baby	Second Stage Duration/ Pushing	Episiotomy/ Tearing	Difficulty healing	Exercise after
1.						
2.						
3.						

URINARY SYMPTOMS

Urge Incontinence	Yes	No	Stress Incontinence	Yes	No
Mixed Incontinence	Yes	No			
Difficulty making it to the toilet	Yes	No	Amount of warning before urination_____minutes		
Accidents per day	_____/day		Small _____ or Large_____		
Padding	Yes	No	Type of pads_____ # of pads/day_____		
Voiding Frequency	_____/day		Painful urination	Yes	No
	_____/night		Dribbling after urination	Yes	No
Trouble starting stream	Yes	No			

Please, **circle those activities** that provoke uncontrolled urination: cough/sneeze, laughing, Lifting, Active Exercise (running, jumping,etc), Minimal exercise (walking), sleeping, Nervousness/anxiety, sit to stand, leakage without specific cause, other_____

"Falling out" feeling	Yes	No			
Fluid Intake per day	_____glasses/day		How many are caffeinated?_____/day		
Bowel Incontinence	Yes	No	Frequency	_____/day or week	

MEDICATION

Aspirin	Yes	No	Tylenol/acetaminophen	Yes	No
Advil/Motrin/Ibuprofen	Yes	No	Laxatives	Yes	No
Pain Relievers (Vicodin, Percocet)	Yes	No	Muscle Relaxants (valium)	Yes	No
Birth Control Pills	Yes	No	Hormone Replacement (Estrogen/progesterone)	Yes	No
Water Pills (diuretics, Laxix)	Yes	No	Antibiotics	Yes	No
Decongestants/antihistamines (Codeine, Ephedrine)	Yes	No	Antidepressant Medication (Lexipro, Prozac)	Yes	No
Vitamins/Supplements/Herbals	Yes	No	Stomach/ulcer Medication	Yes	No
High blood Pressure Medication (Lopressor)	Yes	No	Cholesterol Medication (Lipitor, Zocor)	Yes	No

Other_____