women's & men's health PHYSIOTHERAPY

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IN INFO
SURNAME……
CLIENT # ……..
PHYSIO'S INITIALS……
CONSULT DATE……

# GENERAL HISTORY

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:** _____ **Date:** / /

**Age:** _____ **Height:** _____ **Weight:** _____

## PAST SURGICAL HISTORY: (Please record date and surgeon)

1. Bladder surgery (e.g. colposuspension / sling, prostatectomy, TURP 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 | ☐ Thyroid |
| ☐ Chronic cough/ Asthma | ☐ Prolonged standing | ☐ Other (please specify)…… |

**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?

**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:** (If relevant) 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: …….. |

**MEDICATIONS*:***
Please list details of your current medications (including vitamins, hormone replacement therapy, 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: ☐Yes ☐No
If yes: ☐ Group / class ☐ Verbal instruction
☐ Individual assessment. Name of place: ……

**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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**YOUR THOUGHTS**

Please answer these 7 questions regarding your problem, circling the number that reflects your feelings:

| | **Strongly Disagree** | | | | **Strongly Agree** |
|---|---|---|---|---|---|
| "I find it hard to cope with my problem" | 1 | 2 | 3 | 4 | 5 |
| "I can't manage my problem without medication" | 1 | 2 | 3 | 4 | 5 |
| "I seem to spend a lot of time thinking about my problem" | 1 | 2 | 3 | 4 | 5 |
| "I feel that there is nothing I can do about my problem" | 1 | 2 | 3 | 4 | 5 |
| "I feel that my problem is terrible and that it's never going to get any better" | 1 | 2 | 3 | 4 | 5 |
| "I often wonder if anything more serious is wrong" | 1 | 2 | 3 | 4 | 5 |
| "I can't enjoy all the things I used to enjoy" | 1 | 2 | 3 | 4 | 5 |

**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.**