Kamin Physical Therapy, Inc.

Visit us at www.kaminpt.com

UROGYNECOLOGY-Patient History
Please complete and return to Jean at Kamin Physical Therapy prior to your first visit.

Today's Date: ____/____/____

Name: __________________________________

Occupation: ___________________________

Referred by: (**check one**) ____ self____ family____ friend____ doctor____ other

Name of person making referral: _____________________________________

Who is your primary care physician? _________________________________

What is your current gynecologic/urogynecologic problem?

(Please describe your current symptoms and when they started)

____

____

____

Have you had previous treatments for this problem? ____Yes ____No

(If so, please describe including any medications, physical therapy and/or surgery)

____

____

____

Please list the names of other physicians you have seen for this problem:

____

____

____

List any drug allergies (and reaction)	List current medications (and dosage)
____________________________________	____________________________________
____________________________________	____________________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

GYNECOLOGIC HISTORY

Age when periods first started: ____________

Do you still have periods? _____Yes _____No

If yes, are your periods regular? _____ Yes _____No

Date most recent period started: ________________

Birth control method: ______________________________

Have you had a hysterectomy? _____Yes _____No

If yes, at what age? _____ Reason: ________________

Were ovaries removed? _____Yes ____ No

Have you reached menopause? _____Yes _____ No

Are you taking estrogen therapy? _____ Yes _____ No

Are you currently sexually active? _____ Yes _____ No

Any history of sexually transmitted diseases? _____ Yes _____ No

If yes, please describe ____

When was your last Pap smear? _______________________

Have you had abnormal Pap tests? _____ Yes _____ No

When was your last Mammogram? ____________________

OBSTETRIC HISTORY

Number of pregnancies _____; children _____;

Miscarriages _____; abortions _____

Please list dates and outcomes of all pregnancies:

____

____

____

____

____

PREVIOUS OPERATIONS (Type and Date) HOSPITALIZATIONS (non-surgical)

______________________________ ______________________________

______________________________________ ___________________________________

______________________________________ ___________________________________

______________________________________ ___________________________________

______________________________________ ___________________________________

______________________________________ ___________________________________

MEDICAL HISTORY/FAMILY HISTORY

Do you or any of your relatives have a history of the following?

	You	**Relative**	**(relation to you)**
Anemia	____	______	______________
Bleeding tendency	____	______	______________
Cancer	____	______	______________
Colitis/Bowel trouble	____	______	______________
Depression	____	______	______________
Diabetes	____	______	______________
Glaucoma	____	______	______________
Heart Disease	____	______	______________
High Blood Pressure	____	______	______________
Kidney Disease	____	______	_______________
Liver disease/ Hepatitis	____	______	_______________
Lung Disease/ Asthma	____	______	_______________
Migraine Headaches	____	______	_______________
Osteoporosis	____	______	_______________
Psychiatric disorder	____	______	_______________
Seizures/Epilepsy	____	______	_______________
Thyroid Disease	____	______	_______________
Stroke	____	______	_______________
Ulcers	____	______	_______________
Vein trouble/ Blood clots	____	______	_______________

Other: ____

Do you have a history of sexual, physical, mental or verbal abuse? _____ Yes _____ No

If yes, please circle which one would apply to you:

Have you had any previous fractures? _____ Yes _____ No

Any other serious injuries? _____ Yes _____ No

Have you had any blood transfusions? _____ Yes _____ No

HABITS

Do you smoke? _____ Yes _____ No

Do you drink alcohol? _____ Yes _____ No

Do you drink coffee? _____Yes _____ No

Do you use recreational drugs? _____ Yes _____ No

URINARY FUNCTION QUESTIONAIRE **Please Circle**

1) Have you had treatment for your urinary tract disease such as stones, kidney disease, infections, tumors, injuries? (If yes, please circle all that apply) **YES NO**

2) Have you had repeated urinary tract infections? **YES NO**

3) Is your urine ever bloody? **YES NO**

4) Do you lose urine as a constant drip from your vagina? **YES NO**

5) Is it usually painful or difficult to pass urine? **YES NO**

6) When you lose urine, are you aware it is passing? **YES NO**

7) Do you have to empty your bladder frequently? **YES NO**

8) What volume of urine do you usually pass? **Large, Average, Small, Very Little**

9) Do you get up during the night to urinate? **YES NO**

(If yes, how many times each night? _____)

10) Do you have any burning during or after urination? **YES NO**

11) Do you have a problem controlling bowel movements? **YES NO**

12) Have you ever had paralysis, polio, multiple sclerosis, serious back injury,

cyst or tumor on your spine, tuberculosis, syphilis, stroke, or diabetes?
(If yes, circle all that apply) **YES** **NO**

13) Do you ever wet the bed? **YES** **NO**

14) Does the sound, sight or feel of running water cause you to lose urine? **YES** **NO**

15) When your bladder is full, do you have to run to the nearest bathroom? **YES** **NO**

16) Do you ever lose urine when trying to reach the bathroom? **YES** **NO**

17) Do you lose urine when resting, either lying or sitting down? **YES** **NO**

18) Does your bladder ever empty completely without you being able to stop it? **YES** **NO**

19) Is it necessary for you to change positions (sitting or standing) in order to empty your bladder completely? **YES** **NO**

20) Do you lose urine during coughing, sneezing, laughing or lifting? **YES** **NO**

21) Do you have difficulty holding urine if your suddenly stand up from a sitting or lying position? **YES** **NO**

22) Is your control of urine good unless you cough, sneeze, lift or strain? **YES** **NO**

23) When you are urinating, can you usually stop the flow? **YES** **NO**

24) Do you find it necessary to wear protection because you get wet?
(If yes, how many pads per day? _____) **YES** **NO**

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