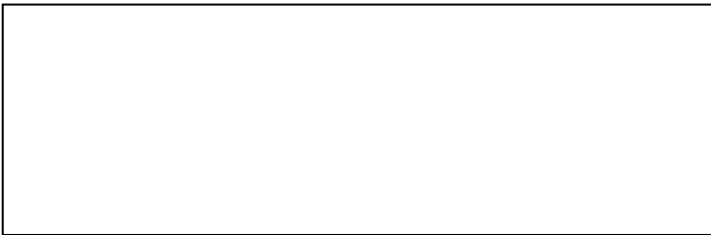


- Maplewood Phone: 651/ 232-7820 Fax: 651/ 232-7832
- Oakdale Phone: 651/ 232-5075 Fax: 651/ 232-5085
- University Park/Midway Phone: 651/ 232-5412 Fax: 651/ 232-4971
- Woodwinds/Woodbury Phone: 651/ 232-6767 Fax: 651/ 232-6766

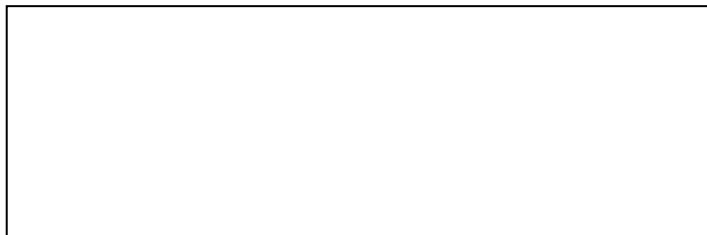


MEDICAL HISTORY/SUBJECTIVE INFORMATION - WOMEN'S HEALTH

Name you Prefer: _____		Next M.D. Visit Date: _____	
Allergies/Reactions: _____			<input type="checkbox"/> None
Sensitivities: <input type="checkbox"/> Elastic <input type="checkbox"/> Latex <input type="checkbox"/> Tape <input type="checkbox"/> None			
Medications Currently Taking: <input type="checkbox"/> None		Purpose	Medication: Purpose
Have you ever been diagnosed with any of the following? <input type="checkbox"/> None			
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer (Specify _____)	
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Heart Disease/Condition	<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Metal Implant	
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____	
Surgeries or other Procedures: _____		Date: _____	Date: _____
How would you rate your stress level? <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High			
In the past year, have you been a victim of abuse (physical, emotional, financial or sexual)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How do you best learn? Please circle: Listening Pictures Watching Reading			
Gynecological History:			
# of pregnancies: _____		# of vaginal deliveries _____	length of pushing _____
# of episiotomies: _____		Do you have a painful episiotomy scar? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a history of urinary track infections? <input type="checkbox"/> Yes <input type="checkbox"/> No		# of C-sections: _____	
When was your Menopause Onset? _____			
Do you have a history of urine loss:			
<input type="checkbox"/> As a child		<input type="checkbox"/> As an adolescent <input type="checkbox"/> After child birth	
Have you been diagnosed with:			
<input type="checkbox"/> Cystocele		<input type="checkbox"/> Rectocele <input type="checkbox"/> Uterine prolapse	
Have you been on Hormone Replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dosage		Type	Years
Estrogen: _____		Pills _____ Patch _____ Cream _____	_____
Progesterone: _____		Pills _____ Patch _____ Cream _____	_____
Previous Treatment for Incontinence:			
Have you tried exercises to control urine loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your doctor prescribed any medication to treat urine loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any surgical procedures to treat urine loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you experience a loss of urine:			
With coughing, laughing, sneezing?		<input type="checkbox"/> Yes <input type="checkbox"/> No	When you have a strong urge to urinate? <input type="checkbox"/> Yes <input type="checkbox"/> No
When lifting heavy objects?		<input type="checkbox"/> Yes <input type="checkbox"/> No	On the way to the bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No
With exercise, running?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Just as getting to the toilet/removing clothes? <input type="checkbox"/> Yes <input type="checkbox"/> No



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Do you:	
Experience an urge to urinate when you hear running water?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have difficulty initiating a urine stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have difficulty stopping a urine stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have pain with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have to strain to empty your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dribble urine when you are urinating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dribble after you empty your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any pelvic area pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe and rate on scale of 0-10. _____	
Voiding/Urinating patterns	
Voiding frequency: # of times a day _____	# of times a night _____
Incontinence # of episodes a day _____	# of episodes a night _____
Amount of urine lost: <input type="checkbox"/> Large <input type="checkbox"/> Small <input type="checkbox"/> Few drops	
What type of protective devices do you use? (check all that apply)	
<input type="checkbox"/> Pantyliner <input type="checkbox"/> Incontinence pad (<input type="checkbox"/> Poise <input type="checkbox"/> Attends <input type="checkbox"/> Serenity)	
<input type="checkbox"/> Sanitary pad (mini) <input type="checkbox"/> Incontinence brief	
<input type="checkbox"/> Sanitary pad (maxi) <input type="checkbox"/> Other: _____	
# of pads used each day? _____	
Do you soak the pad fully? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you change the pad each time it is wet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Daily Fluid Intake:	
# of cups/day _____ Of those, how many are caffeinated and/or carbonated? _____	
Do you restrict fluids because of your incontinence? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	
How severe would you rate your urinary incontinence 0 1 2 3 4 5 6 7 8 9 10	
No impairment Severe	
IF YOU ARE EMPLOYED, COMPLETE THE FOLLOWING SECTION <input type="checkbox"/> Not employed <input type="checkbox"/> Retired	
1. What is your job title/occupation: _____	
2. What are your job activities and work positions? _____	
3. Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of hours per week _____ <input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted Duty	
Do you have problems with dizziness or balance? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you fallen in the last 6 months? <input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, please describe: _____	
PATIENT SIGNATURE: _____	
NOTES: _____	

GOALS: What do you expect to accomplish with PT / OT? _____	
CONSENT: I agree with the treatment plan of care. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ patient initials	
ABUSE: <input type="checkbox"/> Yes <input type="checkbox"/> No Refer to Social Services _____	
FALLS: Is patient at risk? <input type="checkbox"/> Yes <input type="checkbox"/> NO; Assessment Completed: <input type="checkbox"/> Berg or Tinneti <input type="checkbox"/> APTA <input type="checkbox"/> _____	
Therapist's Printed Signature: _____ Date: _____	