Marina D. Castellanos PT, PLLC
www.marinacpt.com
914-552-9639

WOMEN'S PELVIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your care better. Please complete all pages **prior to** your appointment.

Patient Name:_____DOB: _____ Today's Date: _____
Age _____Height_____Weight_____
Address:_____
_____
Insurance:_____

Describe the reason for your appointment_____
When did this problem begin? _____Is it getting better____worse_____staying the same _____
Name and date of last doctor visit _____ Date of last urinalysis_____

Medications	Start date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does you now have or have had a history of the following? Explain all "yes" responses below.

Y/N Pelvic pain
Y/N Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries
Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
Y/N High Blood Pressure____

Explain yes responses and include dates_____
Please list ALL other medical conditions and/or health concerns:
_____
_____
_____
Do you need to be catheterized? Y/N If yes, how often? _____

How did you hear about Marina D Castellanos PT, PLLC?_____

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Pelvic Floor Therapy Questionnaire

Patient Name:_____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____Number of vaginal deliveries_____
Birth weight of largest baby _____ Number of cesarean deliveries_____
Number of episiotomies _____ Date of last pap smear_____

Did you have any trouble healing after delivery? Y N

Do you have a history of sexual abuse or trauma? Y N

Are you having regular periods/ menstrual cycles? Y N

Do you have frequent urinary tract infections? Y N

Pain

Do you have pain with:

Sexual intercourse Y N

Pelvic exam Y N

Tampon use Y N
Back, leg, groin, abdominal pain Y N

Test results (if applicable)

Urodynamics test Y N Results:_____

Cystoscope Y N Results:_____

Urine test Y N Results:_____

Bowel Test Y N Results:_____

Other_____

Bladder symptoms

Do you lose urine when you:

Cough/ sneeze/ laugh	Y	N	Lift/exercise/dance/jump	Y	N
On the way to the bathroom	Y	N	Have a strong urge to urinate	Y	N
Hear running water	Y	N	Other_____	Y	N

Do you wet the bed Y N

Have burning/ pain with urination Y N

Difficulty starting a stream of urine Y N

Strain to empty your bladder Y N

Feel unable to empty bladder fully Y N

Have a falling out feeling Y N

Have pain with a full bladder Y N

Have an urgency of urination/strong urge to urinate Y N

Urinate more than 7 times/day Y N

Bowel Symptoms

Strain to have a bowel movement	Y	N	Leak/stain feces	Y	N
Include fiber in your diet	Y	N	Have diarrhea often	Y	N
Take laxatives/enema regularly	Y	N	Leak gas by accident	Y	N
Have pain with bowel movement	Y	N			

Have a very strong urge to move your bowels Y N
How often do you move your bowels:___per day, ___per week, consistency of stool_____