WOMEN'S/MEN'S HEALTH HISTORY FORM

Name: _____ Date:_____

Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Age: Height: Weight:
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
If yes, when is your due date? _____
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

For women only:
Number of pregnancies: _____ Number of vaginal births: ____ Number of cesarean births_____
Date of last period:_____
Are your periods regular? **YES** **NO**

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**
Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications, supplements or hormones you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ **Yes** ❑ **No When**_____ **Treatment rec'd**_____

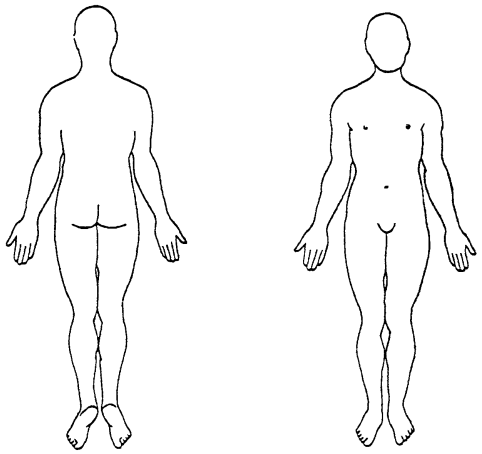
How long did it take for you to feel better? _____

If you have pain, please fill out below:

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past week: _____

The worst your pain has been during the past week: _____

If you have incontinence, bladder urgency or frequency, please fill out the following:

Using the 0-10 scale with 0 being *"no affect"* and 10 being *"severely affected"* please describe how your bladder affects your life: _____

Please check which applies to you:

Daytime Toileting:
- ❑ Every 4 hours
- ❑ Every 2-3 hours
- ❑ Every hour
- ❑ Every 30-59 minutes
- ❑ Other _____

Nighttime Toileting:
- ❑ Rarely/Never
- ❑ Once a night
- ❑ 2-3 times a night
- ❑ More than 3 times a night
- ❑ Other _____

Leaking Urine Nighttime:
- ❑ Rarely/never
- ❑ 1-2 nights per week
- ❑ 2-3 nights per week
- ❑ More than 3 nights per week
- ❑ Other _____

Leaking Urine Daytime:
- ❑ Once every 2 weeks
- ❑ Once per week
- ❑ 2-3 days per week
- ❑ 4 or more days a week
- ❑ Once a day
- ❑ Multiple times a day
- ❑ Constantly all day
- ❑ Other _____
- ❑ Morning primarily
- ❑ Afternoon primarily
- ❑ No pattern

Amount of Urine Leaked:
- ❑ A few drops
- ❑ A small gush or spurt
- ❑ A large leak
- ❑ Varies

Protection Used (if used):
- ❑ Adult continence products _____ per day
- ❑ Sanitary pads _____ per day
- ❑ Pantiliner _____ per day
- ❑ Other _____

Activities Related to Leaking:
- ❑ Coughing/Sneezing
- ❑ Laughing
- ❑ Walking
- ❑ Position Change
- ❑ Sit to Stand
- ❑ Bending/Lifting
- ❑ Running/Jumping
- ❑ Aerobics
- ❑ Water Running/Shower
- ❑ Feeling Cold
- ❑ During Intercourse
- ❑ Before/during Menstration
- ❑ Key in the door
- ❑ When constipated
- ❑ Other_____

Perception of Need to Urinate:

- ❑ No perception of bladder fullness
- ❑ Leaks immediately after awareness
- ❑ Leaks 1-2 minutes after awareness
- ❑ Toileting awareness without problem
- ❑ Other _____

Observations During Urination:

- ❑ Difficulty initiating the stream
- ❑ Weak/slow urine stream
- ❑ Dribbling after the stream ends
- ❑ Feeling like you do not empty all the way
- ❑ Pain during urination
- ❑ Burning during urination
- ❑ Blood in the urine
- ❑ Abnormal color
- ❑ Abnormal odor
- ❑ Other _____

Bowel Patterns:

- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Daily BM
- ❑ BM every 2-3 days
- ❑ BM every 4-5 days
- ❑ Use laxatives
- ❑ Other _____

Fluid Intake:

- ❑ Caffeine consumption (# cups per day)
- ❑ Alcohol intake (# drinks per day)
- ❑ Total fluid consumption (# glasses per day)

Exercise History:

- ❑ Daily
- ❑ 5-6 times per week
- ❑ 3-4 times per week
- ❑ 1-2 times per week
- ❑ None

Describe type and duration _____

Patient Signature _____ Date _____

OR Parent/Guardian signature