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MEDICAL HISTORY FORM — WOMEN

PELVIC HEALTH ASSESSMENT · IN PARTNERSHIP WITH BETTER PELVI

PRACTITIONER COPY · SCORED

Name _____ Date _____

What brings you here?

_____

_____

1. Do you have problems with an uncontrollable urge to urinate? ☐ Yes ☐ No

   1.1 How often per week?
   - ☐ Only 1-2 times a month (+1)
   - ☐ 1-2 times per week (+2)
   - ☐ 3-5 times per week (+3)
   - ☐ Daily (+4)

   1.2 During which activities?
   - ☐ Coughing, sneezing, laughing (+2)
   - ☐ Climbing stairs, lifting heavy objects (+2)
   - ☐ During exercise/sport, running, jumping (+2)
   - ☐ Sometimes just out of nowhere, suddenly (+2)

   1.3 How much urine loss do you experience?
   - ☐ No urine loss
   - ☐ Small amount - just a few drops (+1)
   - ☐ Medium amount - a bit more than a few drops (+2)
   - ☐ Large amount - I can't hold it anymore (+4)

2. How often do you go to the bathroom per day?
   - ☐ 4-6 times
   - ☐ 7-10 times (+2)
   - ☐ More than 10 times (+4)

3. How often do you go to the bathroom per night?
   - ☐ Never
   - ☐ Once (+2)
   - ☐ More than once (+4)

4. Do you frequently have urinary tract infections (UTIs)? ☐ Yes ☐ No

   4.1 How often do you have a urinary tract infection (UTI)?
   - ☐ Only 1-2 times per year (+1)
   - ☐ Every 3-4 months (+2)
   - ☐ Every 1-2 months (+3)
   - ☐ Chronic urinary tract infections (+5)

5. Do you wear pads or panty liners in everyday life? ☐ Yes ☐ No (+4)

6. Do you feel like there is still urine left in the bladder after urination? ☐ Yes ☐ No (+3)

7. Have you given birth to one or more children? ☐ Yes ☐ No

   7.1 How many children?
   - ☐ 1 child (+1)
   - ☐ 2 children (+2)
   - ☐ 3 children (+3)
   - ☐ More than 3 children (+5)

7.2 Was the birth/were the births vaginal or by C-section?

- ☐ Vaginal (+5)
- ☐ C-section (+3)

7.3 How long ago was your last birth?

- ☐ More than 5 years (+1)
- ☐ 3-5 years (+2)
- ☐ 1-3 years (+3)
- ☐ Less than 1 year (CAUTION: May need to consult with a gynecologist to see if treatment is possible) (+4)

7.4 Has your sexual experience been the same as before?

- ☐ Yes
- ☐ No (+4)

8. Have there been any changes in your libido or sexual desire recently? ☐ Yes ☐ No (+4)

9. Do you have pain during sex? ☐ Yes ☐ No (+4)

10. Do you have trouble getting an orgasm? ☐ Yes ☐ No (+4)

11. Is your sensitivity satisfactory? ☐ Yes ☐ No (+4)

12. Do you suffer from pain in the pelvic area or lower back? ☐ Yes ☐ No

12.1 How often do you experience these pains?

- ☐ Only 1-2 times per month (+1)
- ☐ 1-2 times per week (+2)
- ☐ 3-5 times per week (+4)
- ☐ Daily (+5)

13. Have you had surgery in the pelvic area or near the pelvic floor in the past? ☐ Yes ☐ No (+5)

14. Has a pelvic organ prolapse been diagnosed? (pelvic floor prolapse, uterine prolapse, bladder prolapse...) ☐ Yes ☐ No (+5)

15. Have you already undertaken physiotherapy exercises or other measures to improve the strength of your pelvic floor? ☐ Yes ☐ No (+5)

16. How much does your problem affect your daily life and quality of life on a scale of 1-10? (+1-10)

1	2	3	4	5	6	7	8	9	10

SCORE _____ / 100

Notes