

Please circle letters for: Never, Once, Sometimes, Frequent, Always) Or Indicate Yes, No, location & date problem occurred

Do you have an active infection? *Yes / No* Where? \_\_\_\_\_ Are you taking medication? *Yes / No*

High Blood Pressure	<b>N-O-S-F-A</b>	Trouble Emptying Bladder/Bowels	<b>N-O-S-F-A</b>
Angina/chest pain	<b>N-O-S-F-A</b>	Constant Dribbling of Urine	<b>N-O-S-F-A</b>
Heart Arrhythmia	<b>N-O-S-F-A</b>	Blood in Urine/Stool	<b>N-O-S-F-A</b>
Heart Disease	<b>Y/N Date:</b>	Bladder/Bowel Cancer	<b>Y/N Date:</b>
Stroke	<b>Y/N Date:</b>	Childhood Bladder/Bowel Problems	<b>N-O-S-F-A</b>
Pacemaker/metal implant	<b>Y/N Date:</b>	Uterine Fibroids	<b>N-O-S-F-A</b>
Asthma/Emphysema	<b>Y/N Date:</b>	Hormonal Problems	<b>N-O-S-F-A</b>
Shortness of Breath	<b>N-O-S-F-A</b>	Infertility	<b>Y/N</b>
Chronic Cough	<b>N-O-S-F-A</b>	Endometriosis	<b>Y/N</b>
High Cholesterol	<b>Y/N</b>	Pelvic Inflammatory Disease	<b>Y/N</b>
Circulation Problems	<b>Y/N</b>	Pelvic or Abdominal Adhesions	<b>Y/N</b>
Blood Clots	<b>Y/N Date:</b>	Abdominal Pain	<b>N-O-S-F-A</b>
Seizures	<b>Y/N Date:</b>	Pelvic Pain / Pressure	<b>N-O-S-F-A</b>
Cancer	<b>Y/N Date/Location:</b>	Difficulty Sitting	<b>N-O-S-F-A</b>
Tumor	<b>Y/N Date/Location:</b>	Painful Intercourse	<b>N-O-S-F-A</b>
Cysts	<b>N-O-S-F-A</b>	Vaginal Dryness/Burning/Itching	<b>N-O-S-F-A</b>
Systemic Lupus	<b>Y/N</b>	Vaginal Infection	<b>Y/N</b>
Hemophilia	<b>Y/N</b>	Sexually Transmitted Disease	<b>Y/N</b>
Hepatitis	<b>Y/N</b>	HIV/AIDS	<b>Y/N</b>
Liver Disorder	<b>Y/N</b>	Perimenopausal symptoms	<b>Y/N</b>
Yellow Jaundice	<b>Y/N</b>	Post-menopausal symptoms	<b>Y/N</b>
Gall Stones	<b>Y/N</b>	Depression	<b>N-O-S-F-A</b>
Diabetes	<b>Y/N Type:</b>	Anxiety	<b>N-O-S-F-A</b>
Thyroid Problems	<b>Y/N</b>	Hemorrhoids	<b>N-O-S-F-A</b>
Drug/alcohol/tobacco/dependence	<b>Y/N</b>	Anal Fissures	<b>N-O-S-F-A</b>
Recent unexplained weight loss	<b>Y/N</b>	Vaginal/Perineal skin cracking/bleeding	<b>N-O-S-F-A</b>
Recent unexplained weight gain	<b>Y/N</b>	Polyps	<b>N-O-S-F-A</b>
Loss of appetite	<b>N-O-S-F-A</b>	Constipation	<b>N-O-S-F-A</b>
Mononucleosis	<b>Y/N</b>	Diarrhea	<b>N-O-S-F-A</b>
Fatigue	<b>N-O-S-F-A</b>	Irritable Bowel Syndrome	<b>N-O-S-F-A</b>
Allergies (seasonal/otherwise)	<b>N-O-S-F-A</b>	Diverticulitis	<b>N-O-S-F-A</b>
Headaches	<b>N-O-S-F-A</b>	Trouble Holding Back Gas	<b>N-O-S-F-A</b>
Hearing/Vision impaired	<b>Y/N</b>	Prostate problems	<b>N-O-S-F-A</b>
Cataracts	<b>Y/N</b>	Low back pain / sciatica	<b>N-O-S-F-A</b>
Glaucoma	<b>Y/N</b>	Osteoarthritis	<b>N-O-S-F-A</b>
Dizziness	<b>N-O-S-F-A</b>	Arthritis	<b>N-O-S-F-A</b>
Neurological Disorder	<b>N-O-S-F-A</b>	Artificial Joints / Pins	<b>Y/N Date/Location:</b>
Neuropathy	<b>Y/N</b>	Joint Problems	<b>N-O-S-F-A</b>
Gout	<b>N-O-S-F-A</b>	Rheumatoid arthritis	<b>N-O-S-F-A</b>
Anemia	<b>N-O-S-F-A</b>	Fibromyalgia	<b>Y/N</b>
Skin sensitivities	<b>N-O-S-F-A</b>	Osteoporosis	<b>Y/N</b>
Cold Hands and Feet	<b>N-O-S-F-A</b>	Multiple Sclerosis	<b>N-O-S-F-A</b>
Latex allergy	<b>Y/N</b>	Have you had a bone density scan?	<b>N-O-S-F-A</b>
Urinary/bladder/kidney infections	<b>N-O-S-F-A</b>	Have you broken any bones?	<b>N-O-S-F-A</b>
Kidney Stones	<b>Y/N Date:</b>	Hernia	<b>Y/N Location:</b>
Interstitial Cystitis	<b>N-O-S-F-A</b>	Acid Reflux / Heartburn	<b>N-O-S-F-A</b>
Urinary/bowel urgency/frequency	<b>N-O-S-F-A</b>	Head Trauma	<b>Y/N</b>
Urinary or bowel loss of control	<b>N-O-S-F-A</b>	Spinal Cord Injury	<b>Y/N</b>
Trouble Feeling Bladder Fullness	<b>N-O-S-F-A</b>	Do you lose consciousness?	<b>N-O-S-F-A</b>
Trouble Initiating Urine Stream	<b>N-O-S-F-A</b>	Memory problems	<b>N-O-S-F-A</b>

The information that I have provided is complete and accurate to the best of my knowledge and I will obtain any medical test results that relate to my condition.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_ Physical Therapist signature \_\_\_\_\_