

Date_____

Name_____SS#_____DOB_____

Diagnosis_____Referring Physician_____

Brief Description of Chief Complaint/Reason for Referral:

Date symptoms first began:_____

Level of Discomfort/Pain: 0-10 (zero represents no pain)_____

What makes symptoms worse?_____

What makes symptoms better?_____

Date of Last Pelvic Exam_____Abnormal?_____

Please list previous surgeries with the date and reason they occurred:

of Pregnancies_____ # of Live births(incl. birth wt)_____

of Vaginal delivery_____# of Caesarean delivery_____

of Episiotomies_____ # of vaginal tears and grade of tear if known_____

Current Medications/Reason for taking:_____

Allergies ? Please list any drug/environment/food allergies

How physically active are you?

___Very Active (exercise 5-7 days/week)

___Active (exercise 3-5 days/week)

___Somewhat Active (exercise 1-2 days/week)

___Not active (I park in the closest parking spot)

Average fluid intake/day_____

Sleep habits (trouble falling asleep, staying asleep, night waking?)_____

Dr. Sara E. Bolden

Physical Therapist / Women's Health Specialist

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Date _____

Name _____ SS# _____ DOB _____

Medical History: Please check all that apply

High Blood Pressure _____	Diabetes _____
Heart Disease _____	Breathing Problems _____
Osteoporosis _____	Cancer _____
Arthritis _____	Currently Pregnant? _____
Thyroid Condition _____	Allergies (list) _____
Circulation Disease _____	Infectious Disease (HIV, Hepatitis, etc.) _____
Recurrent muscle joint pain problems _____	

Gynecological History: Please indicate all that apply

Have your menstrual periods stopped? Yes _____ No _____
 On hormone replacement therapy? Yes _____ No _____
 Do/did you have pain with your menstrual periods? Yes _____ No _____
 Do/did you have pain with intercourse? Yes _____ No _____
 Endometriosis _____ Prolapse _____ Cysts _____
 Pelvic Inflammatory Disease _____ Fibroids _____ Pelvic Pain _____
 Other (include GYN surgeries) _____

Bowel Habits:

Do/did you experience frequent constipation? Yes _____ No _____
 Do/did you frequently take laxatives? Yes _____ No _____
 Do/did you have incontinence (leakage) episodes? Yes _____ No _____
 How often do you have bowel movements? _____

Urinary Incontinence Symptoms:

How many accidents/day (small? Large?) _____
 Do you wear protection? _____ # of changes/day? _____ # of times urinate/day _____
 Do you leak when you have a strong urge to void? _____
 Do you leak w/coughing _____ Laughing _____ Sneezing _____ Lifting _____ Bending _____ Sex _____
 Are you able to completely empty your bladder? _____ Do you have pain w/urinating? _____
 Do you strain to empty? _____ Any trouble starting your stream? _____

Please list any other symptoms that may be of concern:

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