FMCC Fertility & Midwifery Care Center

A#_____

Female Patient Health History

Patient Name:_____ **Age:**_____ **DOB:**_____

Family Doctor:_____ **Referred By:** _____

Reason for Visit:_____ **Date:** _____

Are you currently pregnant? Circle: YES NO If yes, what week of gestation: _____

Pregnancy History

Total Pregnancies:_____/ Full Term:_____/ Preterm:_____/ Miscarriage:_____/ Abortion:_____/ Ectopic:_____/ Multiple:_____/ Living:_____

DATE	BIRTH WEIGHT	TYPE OF DELIVERY	COMMENTS/COMPLICATIONS

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Additional Obstetrics/Gynecological History

	YES	NO	EXPLAIN:
Currently Breastfeeding?			
Episiotomy or Perineal Tear?			
Difficult Childbirth?			
Do you have Diastasis Recti?			
Difficulty Conceiving?			
Vaginal Dryness?			
Currently on birth control?			Brand: # of days/months on birth control:
History of physical or sexual abuse?			
History of STD's?			If past, please list cure date:
History of/current (circle one) yeast infection?			If history, how many?
History of/current (circle one) UTI?			If history, how many?

Pelvic Health

Do you experience? (check all that apply):

- ☐ Heaviness, dragging, pressure, or bulging in the pelvic area
- ☐ Diagnosis of pelvic organ prolapse
- ☐ Hysterectomy
- ☐ Leaking urine when you cough, sneeze, exercise, etc
- ☐ Unexplained bleeding during or after exercise

Urinary/Bowel

Do you experience? (check all that apply):

- ☐ Strong or sudden urge to urinate
- ☐ Feeling unable to empty your bladder
- ☐ Urinating more than 8 times per day
- ☐ Constipation

SEE BACK

Symptoms

Rate your pain (0= none, 10= worst pain imaginable):

Pain Location	Current	At Best	At Worst
Central Pubic Area			
Lower Back or Sciatica			
Neck			
Tailbone			
Hip			
Other:			

Description of Pain (circle all that apply):

None Stabbing Aching Tender Sore Burning Sharp Shooting

Other: _____

What *increases* your pain?

_____

What *decreases* your pain?

_____

Urinary Leakage

(If not applicable, please disregard this section)

Causes of Leakage (circle all that apply):

None Cough Sneeze On the way to the bathroom Sound of running water
Laugh Lift Sit to Stand Jumping Running Key in door
Walking Other _____

Frequency of Urinary leakage:

_____# episodes per Day / Week / Month (please circle one)

Urine Leaking Amount (circle all that apply):

None Few Drops Wets Pad Wets Underwear Wets Outerwear Other _____

	YES	NO	SOMETIMES		YES	NO	SOMETIMES
Do you wear a pad or protective device?				Have you ever taken medicine to prevent urine loss?			

What do you drink every day? (Circle all that apply):

Water Diet Soda Regular Soda Regular Coffee Decaffeinated Coffee
Other _____ Tea Beer Wine
Liquor Milk Juice

	YES	NO	SOMETIMES		YES	NO	SOMETIMES
Is there a urinary sensation present?				Do you have pain with wiping?			
Once you get the urge to urinate, can you hold it?				Do you go to the bathroom "just in case?"			
Any dribbling after urination?				Do you hover over public toilets when you urinate?			
Can you stop your urine once started?				Did you experience urinary issues as a child?			
Do you Kegel when you urinate?				Do you have a feeling of falling out or heaviness in your pelvis? *If yes/sometimes, see below*:			
Do you have pain or burning with urination?				For the above question, please circle any applicable descriptions: With Menses / Standing / Straining / All the time / At End of day			

Quality of Life

What is your primary goal for occupational therapy?

What activities are important to you?

Activity	Affected	Unaffected	Explain

Is there anything you have stopped doing due to your symptoms?

Did you experience your symptoms prior to pregnancy?

Rate your stress level on a scale of 0-10 (0= none, 10= extreme).

Are you currently exercising? If so, please describe duration, type, and frequency.

Have you seen a pelvic floor specialist in the past? If so, what did they work on, and how did you feel about the results?