HPI PELVIC HEALTH

History of Present Illness

Why are you here today? (Select all that apply)

- ☐ a surgery
- ☐ difficulty with bladder control
- ☐ difficulty with intercourse
- ☐ pain
- ☐ constipation
- ☐ difficulty with bowel control
- ☐ oncology related complications
- ☐ urinary retention

Additional Comments:

When did this begin?

Do you have pain? Yes / No

Which side? (Select all that apply)

- ☐ left
- ☐ right
- ☐ both
- ☐ central

Where is the pain located? (Select all that apply)

- ☐ genitals
- ☐ lower back
- ☐ vagina
- ☐ clitoris
- ☐ bladder
- ☐ ureter
- ☐ lower abdominal area
- ☐ testicle
- ☐ rectum
- ☐ abdomen
- ☐ hip
- ☐ penis
- ☐ kidney
- ☐ urethra
- ☐ uterus
- ☐ scrotum
- ☐ anus
- ☐ thighs

What makes this pain worse? (Select all that apply)

- ☐ bowel movement
- ☐ diet
- ☐ erection
- ☐ light activity
- ☐ sneezing
- ☐ stress
- ☐ urination
- ☐ walking
- ☐ coughing
- ☐ ejaculation
- ☐ intercourse
- ☐ sitting
- ☐ standing
- ☐ underwear touching genital area
- ☐ vigorous activity
- ☐ wiping after toileting

What makes this pain better? (Select all that apply)

- ☐ nothing
- ☐ rest
- ☐ ice
- ☐ injections
- ☐ dilator
- ☐ lying down
- ☐ avoidance of painful activity
- ☐ heat
- ☐ medication
- ☐ physical therapy
- ☐ intercourse

How would you describe this pain? (Select all that apply)

- ☐ dull
- ☐ ripping
- ☐ stinging
- ☐ intermittent
- ☐ shooting
- ☐ bloated
- ☐ sore
- ☐ sharp
- ☐ aching
- ☐ pressure
- ☐ stabbing
- ☐ throbbing
- ☐ constant

Do you have other symptoms?

Have you had any diagnostic tests done? (Select all that apply) Yes / No

- ☐ biopsy
- ☐ CT scan
- ☐ cystoscopy
- ☐ MRI
- ☐ MRN (magnetic resonance neurography)
- ☐ pudendal nerve block
- ☐ sonogram
- ☐ urodynamic testing
- ☐ Xray

Do you currently have numbness and tingling? Yes / No

If yes, where? (Select all that apply)

- ☐ right lower extremity
- ☐ abdominals
- ☐ left lower extremity
- ☐ genitals
- ☐ lower back

Have you had any urinary tract infections? Yes / No

If yes, how many have you had in the lst 6 months?

- ○ 0-2
- ○ 2-5
- ○ > 5

Were cultures taken? Yes / No

Additional Comments:

Bladder

Are you here for bladder issues? If no, skip this section. Yes No

Do you experience urinary leakage? Yes No

When does it occur?
- ☐ laughing
- ☐ sneezing
- ☐ coughing
- ☐ lifting
- ☐ jumping
- ☐ walking
- ☐ running
- ☐ during intercourse
- ☐ walking to the bathroom
- ☐ pulling down pants to urinate
- ☐ walking from the car to the house
- ☐ putting keys into the lock of the front door
- ☐ during a shower
- ☐ running water

How many times do you experience urinary leakage? (Select one)
- ○ 1-2 times per day
- ○ 2-3 times per day
- ○ 3-4 times per day
- ○ 4-5 times per day
- ○ > 5 times per day
- ○ 1-2 times per week
- ○ 2-3 times per week
- ○ 3-4 times per week
- ○ 4-5 times per week
- ○ > 5 times per week

What is the amount of your urinary leakage? (Select all that apply)
- ☐ a few drops
- ☐ a teaspoon
- ☐ large enough to wet underwear
- ☐ large enough to run down leg

Do you wear protection for urinary leakage? Yes No

What type of protection do you wear? (Select all that apply)
- ☐ panty liners
- ☐ small pads
- ☐ medium pads
- ☐ large pads
- ☐ multiple pads at one time
- ☐ full briefs
- ☐ sanitary napkins
- ☐ incontinence products

How many pads to you wear in a day? (Select one)
○ 1-2 ○ 3-4 ○ 4-6 ○ > 6

Do you wear a pad at night? Yes No

How often do you urinate during the day? (Select one)
- ○ every hour
- ○ every 2 hours
- ○ every 3 hours
- ○ every 4 hours
- ○ > 4 hours

How many times do you get up at night to urinate? (Select one)
○ 0 ○ 1 ○ 2 ○ 3 ○ > 3

Are you able to delay urination? Yes No

If yes, how long? (Select one)
- ○ < 10 min
- ○ 10-15 min
- ○ 30 min
- ○ 1 hour
- ○ > 1 hour

Are you able to stop your urine midstream while on the toilet? Yes No

Is there any hesitation in the initiation of your urine stream? Yes No

WOMEN ONLY: Do you sit with normal posture when you are on the toilet? Yes No

What beverages do you typically drink during the day? (Select all that apply)
- ☐ coffee/regular
- ☐ coffee/decaf
- ☐ tea/regular
- ☐ tea/decaf
- ☐ carbonated beverages/regular
- ☐ carbonated beverages/decaf
- ☐ water
- ☐ sports drinks
- ☐ orange juice
- ☐ alcohol

How many fluid ounces of liquid are you drinking during the day? (Select one)
- ○ < 8 cups (< 64 ounces)
- ○ approx 8 cups (64 ounces)
- ○ > 8 cups (> 64 ounces)

Additional Comments:

Bowels

Are you here for bowel issues? If no, skip this section. Yes No

Do you experience bowel leakage? Yes No

Do you wear protection for bowel leakage? Yes No

If yes, what type of protection do you wear? (Select all that apply)

- ☐ panty liners
- ☐ small pads
- ☐ medium pads
- ☐ large pads
- ☐ multiple pads at one time
- ☐ full briefs
- ☐ sanitary napkins
- ☐ incontinence products

Do you ever get fecal smearing on your underwear? Yes No

How often do you have a bowel movement? (Select one)

- ☐ 1 time per week
- ☐ 2 times per week
- ☐ 3 times per week
- ☐ every other day
- ☐ every day
- ☐ multiple times per day
- ☐ less than 1 time per week

What does your stool look like most of the time? (Select all that apply)

- ☐ small hard lumps (Type 1 Bristol Stool)
- ☐ a large hard sausge and very lumpy (Type 2 Bristol Stool)
- ☐ a large sausage with many cracks on the surface (Type 3 Bristol Stool)
- ☐ a ripe banana (Type 4 Bristol Stool)
- ☐ soft blobs with clear cut edges (Type 5 Bristol Stool)
- ☐ fluffy pieces with ragged edges/mushy (Type 6 Bristol Stool)
- ☐ no solid pieces and watery (Type 7 Bristol Stool)

Is your stool hard? Yes No

Do you take anything to make it softer? Yes No

If yes, select all that apply:

- ☐ stool softeners
- ☐ laxatives
- ☐ extra water
- ☐ increased fiber in food
- ☐ fiber supplements
- ☐ enemas

Do you usually have to strain hard to have a bowel movement? Yes No

Do you experience intestional gas? Yes No

If yes, are you able to control it from coming out? Yes No

Do you ever get constipated? Yes No

Do you have hemorrhoids? Yes No

If yes, where?

- ☐ internal
- ☐ external

Additional comments:

Sexual Function

Are you here for sexual problems? If no, skip this section. Yes No

Are you sexually active? Yes No

WOMEN ONLY: Do you have difficulty with intercourse? Yes No

If yes, Why? ☐ pain ☐ tightness

If you have pain, select all that apply
- ☐ pain with manual stimulation
- ☐ pain with movement
- ☐ pain with orgasm
- ☐ pain with penetration
- ☐ pain with sitting
- ☐ post intercourse pain
- ☐ vaginal pain

Do you use a personal lubricant for intercourse? Yes No

MEN ONLY: Do you experience erectile dysfunction? Yes No

If yes, check all that apply:
- ☐ difficulty acheiving erection
- ☐ difficulty maintaining erection
- ☐ pain with ejaculation

Do you take medication for erectile dysfunction? Yes No

Medication taken for this: ☐ Cialis ☐ Viagra ☐ Levitra

Use of pump? Yes No

Additional Comments:

Home Environment

How would you rate your health? ○ excellent ○ good ○ fair ○ poor

Do you exercise regularly? ○ does ○ does not

How many falls have you had in the past 6 months? ○ 0 ○ 1 to 2 ○ >3

What is your employment status? ○ employed ○ unemployed ○ retired

What do you do for a living?

Goals/Followup

What are your goals for therapy?

When are you scheduled to return to the doctor for follow-up?
- ○ as needed
- ○ within 1 month
- ○ after completion of therapy

Additional Comments: