## 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
- rectum
- testicle
- 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
- 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
- shooting
- ripping
- bloated
- stinging
- sore
- intermittent
- sharp
- stabbing
- aching
- throbbing
- pressure
- constant

**Do you have other symptoms?**

**Have you had any diagnostic tests done? (Select all that apply)**
- 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
- left lower extremity
- lower back
- abdominals
- genitals

**Have you had any urinary tract infections?**
- [ ] Yes
- [ ] No

**If yes, how many have you had in the last 6 months?**
- [ ] 0-2
- [ ] 2-5
- [ > 5
- [ ]

**Were cultures taken?**
- [ ] Yes
- [ ] No

**Additional Comments:**
### Bladder

**Are you here for bladder issues?**  Yes  No

If no, skip this section.

**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
- 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
- medium pads
- multiple pads at one time
- sanitary napkins
- small pads
- large pads
- full briefs
- incontinence products

**How many pads do you wear in a day? (Select one)**
- 1-2
- 3-4
- 4-5
- > 5

**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 beverage regular
- carbonated beverage 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.  

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**Do you experience bowel leakage?**  

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**Do you wear protection for bowel leakage?**  

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

**Do you ever get fecal smearing on your underwear?**  

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

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<th>1 time per week</th>
<th>2 times per week</th>
<th>3 times per week</th>
<th>every other day</th>
<th>multiple times per day</th>
<th>less than 1 time per week</th>
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**What does your stool look like most of the time?**  
(Select all that apply)  

- small hard lumps (Type 1 Bristol Stool)
- a large hard sausage 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?**  

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**Do you take anything to make it softer?**  

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

**Do you usually have to strain hard to have a bowel movement?**  

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**Do you experience intestinal gas?**  

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**If yes, are you able to control it from coming out?**  

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**Do you ever get constipated?**  

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**Do you have hemorrhoids?**  

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**If yes, where?**  

- internal
- external

**Additional comments:**  

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**Sexual Function**

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

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 orgasm
- □ pain with sitting
- □ 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 achieving 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: