



Orthopedic & TMJ Physical Therapy Center

Confidential Health Questionnaire

Urinary Incontinence

Name: _____

D.O.B.: _____

Date: _____

Occupation: _____

General Health Questions

1. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- | | | |
|--|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Heart condition | <input type="radio"/> Pregnancy Trauma |
| <input type="radio"/> Arthritis | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Disease |
| <input type="radio"/> Asthma | <input type="radio"/> Hemorrhoids | <input type="radio"/> Respiratory problems |
| <input type="radio"/> Cataracts | <input type="radio"/> High/low blood pressure | <input type="radio"/> Seizures |
| <input type="radio"/> Cancer | <input type="radio"/> HIV, AIDS | <input type="radio"/> Skin Conditions |
| <input type="radio"/> Chest Pains | <input type="radio"/> Irritable Bowel | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Circulatory problems | <input type="radio"/> Kidney/Bladder Stones | <input type="radio"/> Vascular Disease |
| <input type="radio"/> Constipation/Impaction | <input type="radio"/> Migraines | <input type="radio"/> Musculoskeletal |
| <input type="radio"/> Convulsions | <input type="radio"/> Mitral valve prolapse | <input type="radio"/> TMJ <input type="radio"/> Shoulders |
| <input type="radio"/> Diabetes | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Neck <input type="radio"/> Hips |
| <input type="radio"/> Digestive problems | <input type="radio"/> Osteoporosis | <input type="radio"/> Back <input type="radio"/> Knees |
| <input type="radio"/> Dizziness | <input type="radio"/> Osteomyelitis | <input type="radio"/> Feet |
| <input type="radio"/> Eliminatory problems | <input type="radio"/> Osteoporosis | Other _____ |
| <input type="radio"/> Falls | <input type="radio"/> Pacemaker | _____ |
| <input type="radio"/> Fractures | <input type="radio"/> Parkinson's Disease | _____ |
| <input type="radio"/> Head aches | <input type="radio"/> Polyps | |
| <input type="radio"/> Head Injuries | <input type="radio"/> Phlebitis | |

2. When was your last Medical exam? Within last month Within last 6 months More than 6 mo.

3. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? Yes No

4. Do you Smoke? Yes No

5. Do you drink alcohol (if so list # per week)? No. ___ Beer. ___ Wine. ___ Spirits.

6. Education High School College Graduate Professional Training

7. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor,... etc?
 Provider's Name & Specialty

8. Have you ever been treated for any of the following: Anxiety Depression Nervous Problems
 Drug Addiction Alcoholism

9. Do you experience:

- Numbness/tingling/weakness in anywhere in your body
- Pain or discomfort with sexual activity
- Clicking, popping, or pain in your jaw

10. Please list any past injuries and/or accidents (include dates if possible):

11. Have you ever seen a physical therapist before? Yes No

12. Please list all medications you are currently taking (prescription and over the counter)?

Name & Dosage

Reason for taking

13. Daily Fluid Intake & Diet:

Indicate what amount you drink of the following in a typical day. ___Water (8oz.) ___Juice (8oz.)

___ Coffee (cups) ___ Tea (cups) ___ Soda (8oz.)

Do you restrict fluids Yes No

Please describe your diet.

Allergies: medication, food or other

14. Previous Treatment for Incontinence

Have you done exercises (e.g. Kegels) to control urine loss?

Yes No

Is so, were they helpful?

Yes No

Has your doctor prescribed any medication to treat urine loss?

Yes No

Have you had any surgical procedures to treat urine loss?

Yes No

15. Currently

Do you experience a loss of urine... with coughing, laughing, sneezing?

Yes No

with lifting heavy objects?

Yes No

with exercising running, etc?

Yes No

when you have a strong urge to urinate?

Yes No

on the way to the toilet?

Yes No

with "key in lock"?

Yes No

just as getting to toilet/removing clothes?

Yes No

Do you experience an urge to urinate when you hear running water?

Yes No Unsure

have difficulty initiating a urine stream?

Yes No Unsure

have difficulty stopping your stream?

Yes No Unsure

have pain with urination?

Yes No Unsure

have blood in your urine?

Yes No Unsure

have to strain to empty your bladder?

Yes No Unsure

dribble urine when urinating?

Yes No Unsure

dribble urine after urinating?

Yes No Unsure

recognize leakage as it occurs?

Yes No Unsure

With an uncontrolled loss of urine... is it usually a large amount?

Yes No Unsure

Is it usually a small amount?

Yes No Unsure

16. Voiding Patterns:

Voiding frequency: # of times/day _____

of times/night _____

leakage episodes/day _____

leakage episodes/night _____

Amount of urine when voiding ___ large ___ small ___ few drops

22. Psychosocial Status:

Are you sexually active? _____

Is there a history of sexually transmitted diseases? _____

Living arrangements: Do you live alone? Yes No

Have you had to restrict your activities due to incontinence or pain? Yes No

Have you had changes in intimate relationships/sexual functioning due to urinary incontinence or pain? Yes No

Please list exercise, sports, hobbies or musical instruments _____

Please describe your sleeping habits (Snoring, # of hours, position, # of pillows) . _____

23. In your own words please describe your problem: _____

24. **Life Impairment:** What are your feelings about your problem on a scale of 1 to 10?

No Impairment 0 1 2 3 4 5 6 7 8 9 10 Severe Impairment

25. How did you hear about our clinic? _____

THANK YOU