PATIENT CASE HISTORY

myphysio sa for her
Pregnancy · Women's Health · Incontinence

Thank you for taking the time to complete the following questions. Topics on this form may be discussed further with your physiotherapist – please fill in the areas you are comfortable to.
Providing your physiotherapist with this information will help them with their assessment.

Name: _____ Age: _____
Occupation: _____ Height(cm): _____ Weight (kg): _____

Current Situation
What is the problem that bothers you the most?
_____

How long have you had this problem? When did it start?
_____

Have you had this or a similar condition in the past?
_____

How much does your problem bother you? *Please mark the appropriate spot on the line below*:

0 _____ 10
Not bothered at all — Extremely Bothered
I can do everything I want to — I cannot do anything I want to

Since the problem started is it:
☐ About the same ☐ Getting better ☐ Getting worse

Have you seen anyone else with this problem? Yes / No
If yes, please specify which health professional (GP, physio, specialist) and any prior management:
_____
_____
_____

Hormonal Status

Are you currently?	Please circle:
Pregnant	No / Yes > If yes, how many weeks? _____
Breastfeeding	No / Yes
Menstruating Regularly	No / Yes
Menopausal	No / Yes
Post – Menopausal	No / Yes > If yes, age at end of menopause _____

Medication - Please list any current medications:
(including hormone replacement therapy, vitamins, any products for bladder/bowel)
_____
_____

Investigations - Please list any investigations you have had for this problem
(eg: pelvic ultrasound, abdominal X-ray, urodynamic test, blood test etc.)
_____
_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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General Health

Do you have or have you ever had any of the following conditions:

- ☐ Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Psoriasis
- ☐ Osteoporosis
- ☐ Nausea
- ☐ Spinal Surgery
- ☐ Chronic Cough / Hayfever
- ☐ Diabetes
- ☐ Constipation / Straining
- ☐ Bone / Joint Fracture
- ☐ Heart Disease / Angina
- ☐ Spinal Fracture
- ☐ Cancer/Malignancy
- ☐ Stroke
- ☐ Depression / Anxiety
- ☐ Asthma
- ☐ Recurrent UTI / Cystitis
- ☐ Heavy lifting
- ☐ Pelvic Girdle Pain
- ☐ Smoker (Current or Ex)
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Headaches / Migraines
- ☐ Thyroid Problem
- ☐ Psychiatric Illness
- ☐ Thrush
- ☐ Neurological Disease

☐ Any other health problems we should be aware of? *Please List*:

_____

_____

Have you been hospitalised in the past year? Yes / No

If yes, please specify the reasons and duration of admission:

_____

_____

Gynaecological History

When was your last pap smear? Was it normal? _____

Have you ever had an abnormal pap smear? _____

If you are using contraception, which type? _____

Obstetric History

If relevant, please complete details for all deliveries:

Number of Pregnancies: _____

Date	Birth Weight	Mode of Delivery (Vaginal or Caesarean)	Other (eg. Forceps, tear, episiotomy)

Past Surgical History

Please record the date of any previous surgery including bladder, bowel, gynaecological, abdominal surgery:

_____

_____

Do you give us permission to communicate with your Doctor? Yes / No

What two main things would you like to achieve out of today's session?

_____

_____

Patient's Signature: _____ Print Name: _____

Thank you for completing this form, we look forward to discussing your responses during your appointment.

Physiotherapists Signature: _____ Date: _____