MEDICAL HISTORY FORM

NAME: _____ DOB: _____

EMERGENCY CONTACT:
Name: _____ Relationship to patient: _____ Phone: _____

DNR (do-not-resuscitate) order? No If DNR, please provide formal documentation.

Do you have a latex allergy? No

Are you currently taking medication, vitamins, supplements? No If yes, complete **Vitality Medication List.**

Are you allergic to any medication or have other allergies? No If yes, complete **Vitality Medication List.**

How were you referred to Vitality? Check all that apply:

☐ Physician	☐ Family member	☐ Internet
☐ Nurse or midwife	☐ Friend	☐ Social media
☐ Chiropractor	☐ Co-worker	☐ Other _____

Do you have a prescription for physical therapy? No

- If yes: Name of referring physician: _____
- If no: Name of healthcare provider that you would like to have Vitality communicate with: _____

Please list any additional healthcare providers you would like Vitality to send updates regarding your treatment and plan of care: _____

Date of next physician visit (if applicable): _____

Date of injury or onset of symptoms (if known): _____

Have you ever had physical therapy for these or related symptoms? No

- If yes, please describe: _____

Is an attorney involved in this case? No

CHECK ALL THAT APPLY TO YOUR SYMPTOMS RELATED TO THIS COURSE OF CARE:

☐ Work-related injury	☐ Recurrence of previous injury	☐ Childbirth
☐ Motor vehicle	☐ Lifting injury	☐ Falling
☐ Cause unknown	☐ Athletic injury	☐ Other _____

SOCIAL HISTORY

Current working? Yes If on leave, estimated return to work date: _____

Occupation: _____ Full-time

Do you participate in regular sports, physical activity, or exercise programs? Yes

- If yes, please describe: _____

Do you smoke? Yes If yes, how many packs per day or week? _____

- If previously, when did you quit? _____

Do you consume alcohol? No If yes, how many glasses or ounces per day, week, or month? _____

Do you consume caffeine? No If yes, how many glasses per day, week, or month? _____

Estimated daily water intake: _____

Are you experiencing pain? No If yes, please complete **Vitality Pain Questionnaire.**

MEDICAL HISTORY

Check any of the following you currently have or previously have experienced?

HEART DISEASE
- ☐ Chest Pain/Angina
- ☐ High Blood Pressure
- ☐ Heart Attack/MI
- ☐ Heart Palpitations

VASCULAR DISEASE
- ☐ Stroke
- ☐ Blood Clots

LUNG DISEASE
- ☐ Asthma
- ☐ Breathing Difficulties
- ☐ COPD

NEUROLOGICAL
- ☐ Seizures
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches

MUSCULOSKELETAL
- ☐ Fracture
- ☐ Dislocation
- ☐ Osteoarthritis

GASTROINTENSTINAL
- ☐ Hernia
- ☐ Liver/Gallbladder Problems
- ☐ Special Diet Guidelines
- ☐ Nausea/Vomiting

OTHER
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Kidney problems
- ☐ Autoimmune disease
- ☐ Rheumatoid Arthritis
- ☐ Sjogrens
- ☐ Lupus
- ☐ Scleroderma
- ☐ Recent unexplained weight loss
- ☐ Osteopenia/Osteoporososis
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD

BLADDER AND BOWEL SYMPTOMS (history)

Average frequency of urination (purposeful emptying of your bladder) during your waking day: 6-7 times

Average times you wake to urinate during your sleep (bed-time) hours: 0

Average frequency of bowel movements: Once daily

Average time spent on the toilet to complete a bowel movement: 0-2 minutes

Do you currently need to use or have a history of usage of laxatives, enemas or fingers to remove stool? No

Do you usually have an abnormally strong urge to void urine? No

Do you strain for urination? No

Do you have pain with urination? No

Do you experience Urinary Leakage (the accidental loss of urine)? No If yes, please answer the following:

- Onset of urinary leakage (incontinence): _____
- Do you wear pads or liners? No If yes, how many per day: _____

Answer the following questions, thinking about how you have been, on average, over the **PAST FOUR WEEKS.**

- How often do you leak urine? Never

- We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? None

- Overall, how much does leaking urine interfere with your everyday life? 0
  Select a number between 0 – "not at all", and 10 – "a great deal")

- When does urine leak? (Check all that apply to you)

☐ Never - urine does not leak
☐ Leaks when you cough or sneeze
☐ Leaks when you have finished urinating and are dressed
☐ Leaks when you are physically active/exercising
☐ Leaks before you can get to the toilet
☐ Leaks when you are asleep
☐ Leaks for no obvious reason

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by selecting one answer from the drop down. If answering yes, select how much does it bother you. While answering these questions, While answering these questions,please consider your symptoms ***over the last 3 months***.

Do you…

- Usually experience *pressure* in the lower abdomen?
  No
- Usually experience *heaviness or dullness* in the pelvic area?
  No
- Usually have a bulge or something falling out that you can see or feel in your vaginal area?
  No
- Ever have to push on the vagina or around the rectum to have or complete a bowel movement?
  No
- Usually experience a feeling of incomplete bladder emptying?
  No
- Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?
  No
- Feel you need to strain too hard to have a bowel movement?
  No
- Feel you have not completely emptied your bowels at the end of a bowel movement?
  No
- Usually lose stool beyond your control if your stool is well formed?
  No
- Usually lose stool beyond your control if your stool is loose?
  No
- Usually lose gas from the rectum beyond your control?
  No

- Usually have pain when you pass your stool?
  No
- Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?
  No
- Does part of your bowel ever bulge outside the rectum during or after a bowel movement?
  No
- Usually experience frequent urination?
  No
- Usually experience urine leakage associated with a feeling of urgency, i.e. a strong sensation of needing to go to the bathroom?
  No
- Usually experience urine leakage with coughing, laughing, or sneezing?
  No
- Usually experience small amounts of urine leakage (small drops of urine)?
  No
- Usually experience difficulty emptying your bladder?
  No
- Usually experience *pain or discomfort* in the lower abdomen or genital region?
  No

If you answered yes to any of the questions related to abnormal bladder or bowel function please describe frequency of symptoms, date of onset if known, prior history: _____

_____

_____

_____

WOMEN'S AND PELVIC HEALTH QUESTIONS:

Menstrual cycle history

- Age at first cycle: _____
- Would you say that your cycles are regular in duration and frequency? Yes
  - If no, briefly explain or list age of last cycle: _____
- Do you have current or history of pain inserting tampons? Yes
- Are you taking birth control? Yes
  - Duration and type: _____
- Pain with cycle: Yes
- Do you ever miss work or social events due to your period? Yes

Sexual function history

- Are you currently sexually active? Yes
- Do you currently have or have a history of pain with intercourse? Yes
- If yes, please check when pain is present:
  - ☐ Initial insertion
  - ☐ Deep penetration
  - ☐ Oral stimulation
  - ☐ With orgasm
- Age symptoms of pain with sexual activity began: _____
- Are you able to experience orgasm? Yes

Obstetric history

Are you currently or have you ever been pregnant? Yes If yes, please answer the following:

- If currently pregnant, estimated due date: _____ Anticipated delivery method: _____
- # of pregnancies: _____
- # and dates of live births: _____
- Method of delivery (include #):
    - Vaginal birth _____ Cesarean birth _____
        - Instruments used in delivery: vacuum _____ forceps _____
        - Presence/grade of tearing with vaginal delivery (if applicable): _____
- Pain during pregnancy and location of pain: _____
- Other complications? Please describe _____

Additional Medical History

Have you ever been diagnosed with any of the following conditions? Yes

If so, date of diagnosis or describe treatment provided.

☐ Endometriosis _____
☐ Polycystic Ovarian Syndrome _____
☐ Infertility _____
☐ Fibroids _____
☐ Ovarian cysts _____
☐ Pre-eclampsia _____
☐ Gestational diabetes _____

SURGICAL HISTORY: Please list name, date and details for past surgeries: _____

_____

_____

_____

_____

_____

_____

ANY OTHER INFO REGARDING PAST MEDICAL HISTORY WE SHOULD KNOW?

_____

_____

_____

_____

Patient signature: _____ **Date:** _____

Signature of guardian: _____ Date: _____

Physical Therapist: _____ **Date:** _____