Patient Record - General Information

Name	Primary MD
DOB	Referred by
Address	
Phone	

Marital Status:	☐ Married	☐ Single	☐ Divorced	☐ Widowed	
Living Arrangements:	☐ Self	☐ With spouse	☐ Assisted Living	☐ Skilled Nursing	☐ Other
Occupation/ Work History					
Educational Level	☐ Grade School	☐ High School	☐ College	☐ Graduate School	

Allergies	☐ Y	☐ N	Describe:			
Smoking	☐ Y	☐ N	Packs/day:		How long?	
Exercise Habits						

Current Medications – Include prescription and over-the-counter

Drug	Treatment for	Dose	Time	Drug	Treatment for	Dose	Time

Medical & Surgical History

	Self	Family		Self	Family
Heart Disease	☐ Y ☐ N	☐ Y ☐ N	Back Injury	☐ Y ☐ N	
Hypertension	☐ Y ☐ N	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	☐ Y ☐ N
Diabetes	☐ Y ☐ N	☐ Y ☐ N	Cancer	☐ Y ☐ N	☐ Y ☐ N
Stroke	☐ Y ☐ N	☐ Y ☐ N	Alzheimer's Disease	☐ Y ☐ N	☐ Y ☐ N
Respiratory/Lung	☐ Y ☐ N	☐ Y ☐ N	Depression	☐ Y ☐ N	☐ Y ☐ N
Parkinson's Disease	☐ Y ☐ N	☐ Y ☐ N	Bladder repair	☐ Y ☐ N	
Blood Clots	☐ Y ☐ N	☐ Y ☐ N	Spine/back surgery	☐ Y ☐ N	
Thyroid Disease	☐ Y ☐ N	☐ Y ☐ N	Multiple Sclerosis	☐ Y ☐ N	☐ Y ☐ N
Hysterectomy	☐ Y ☐ N		Other	☐ Y ☐ N	☐ Y ☐ N
Prostatectomy	☐ Y ☐ N		Describe Other:		
If yes, to any of the above, please describe:					

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Patient Record - General Health Assessment

SKIN			
Sores that do not heal	☐ Y ☐ N	Where?	
Open areas	☐ Y ☐ N		
Other	☐ Y ☐ N		
EYES			
Pain	☐ Y ☐ N	Glaucoma	☐ Y ☐ N
Sudden decrease or loss of vision	☐ Y ☐ N	Other	☐ Y ☐ N
RESPIRATORY			
Frequent chest congestion	☐ Y ☐ N		
Shortness of breath	☐ Y ☐ N		
CARDIAC			
Chest pain/angina	☐ Y ☐ N	Palpitations	☐ Y ☐ N
Swelling of ankles	☐ Y ☐ N	Leg/calf aching with walking	☐ Y ☐ N
GASTROINTESTINAL			
Abdominal pain/cramping	☐ Y ☐ N		
Change in bowel habits	☐ Y ☐ N		

BOWEL PATTERNS				
Frequent diarrhea	☐ Y ☐ N	Bowel movements every 2-3 days	☐ Y ☐ N	Type of laxative:
Frequent constipation	☐ Y ☐ N	Bowel movements every 4-5 days	☐ Y ☐ N	
Daily bowel movements	☐ Y ☐ N	Use of laxatives	☐ Y ☐ N	
APPETITE				
☐ Good ☐ Fair ☐ Poor		Weight loss/gain of more than 5 lbs. in past year?	☐ Y ☐ N	Explain:

SLEEP/REST					
Bedtime		# times up/ night to urinate		Able to get back to sleep?	☐ Y ☐ N
Awake time		# times/waking hours to urinate		Sleep aids? (List)	

MUSKULOSKELETAL			
Arthritis	☐ Y ☐ N	Any falls in last 6 months?	☐ Y ☐ N
Foot problems	☐ Y ☐ N		
NEUROLOGICAL			
Tremors or shakiness	☐ Y ☐ N		
Numbness	☐ Y ☐ N		
PSYCHOLOGICAL			
Depression/sadness	☐ Y ☐ N		
Anxiety	☐ Y ☐ N		
GENITOURINARY			
Incontinence	☐ Y ☐ N	Urgency	☐ Y ☐ N
Hesitancy	☐ Y ☐ N	Frequency	☐ Y ☐ N
CHIEF COMPLAINTS			

Women Only

Number of Pregnancies		Number of Vaginal births		Number of C sections	
Menopause	☐ Y ☐ N	Date of onset		Age of onset	
History of breast lumps?	☐ Y ☐ N	Date			
History of breast cancer?	☐ Y ☐ N	Date			
Abnormal uterine bleeding	☐ Y ☐ N	Treatment			
Trouble with prolapse	☐ Y ☐ N				
Pain/itching in vaginal area	☐ Y ☐ N	Date of last pelvic exam			

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Patient Record - Urinary Health Assessment

Approximate duration of urinary symptoms in years:				
Did your bladder control challenges start with a particular event? (surgery, pregnancy, illness, new medications, stroke, etc?)	☐ Y ☐ N	Explain:		
Have you been diagnosed with incontinence?	☐ Y ☐ N	If yes, when?		
		What type? ☐ Stress Incontinence ☐ Mixed Incontinence ☐ Overactive Bladder ☐ Other ☐ Urge Incontinence		
		Other describe:		
Have you had treatment before?	☐ Y ☐ N	What?	When?	Stopped? Why?

How much urine do you leak? ☐ Few drops ☐ Large leaks ☐ Varies

When do you leak urine? ☐ Anytime ☐ Daytime ☐ Nighttime ☐ Bedtime ☐ Up in AM ☐ 1st foot out of bed

Do you leak during activities? ☐ Cough/sneeze/laugh ☐ Feeling cold ☐ Walking ☐ Intercourse ☐ Bending/lifting ☐ Aerobics/jumping ☐ Change in position ☐ Other

How often do you leak urine? ☐ Once/wk ☐ 2-3 x/wk ☐ Everyday Once/day ☐ 2 x or more/day ☐ Constantly

How often do you urinate during the day? ☐ Every ½ hour ☐ Every hour ☐ Every 2 hours ☐ Every 3+ hours

How often do you get up to urinate at night? ☐ 0-1 times ☐ 2-3 times ☐ 4+ times

Pain or burning with urination? ☐ Y ☐ N

Frequent urinary tract infections? ☐ Y ☐ N

Perception of need to urinate? ☐ Never know when bladder is full ☐ Leak immediately after awareness ☐ Leak 1-2 minutes after awareness ☐ Know when to urinate; can't get to bathroom on time

Are there times you don't make it to the bathroom? ☐ Never ☐ Once/wk ☐ 2-3 times/wk ☐ Once/day ☐ 2 times/day ☐ 3+ times/day

Protection used? ☐ Heavy pads (#___) ☐ Mod. thick pads (#___) ☐ Panty liners (#___) ☐ Varies ☐ Nothing ☐ Other

Daily Fluid Intake

# of cups of fluid per day		# of cups of caffeine consumption/day (coffee, tea, pop)		Alcohol intake (beer, wine, liquor) drinks/day	

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Patient Goals

- ☐ ↓ Urgency
- ☐ ↓ Frequency
- ☐ No accidents
- ☐ Sleep through night
- ☐ Void every ____ hours
- ☐ No leaks during intercourse
- ☐ Other:

____

____

____

Treatment Plan

- ☐ ↑/↓Fluids
- ☐ Dietary changes ________________________________
- ☐ ↓ Caffeine
- ☐ ↓ Alcohol
- ☐ Urge reduction techniques
- ☐ Pelvic floor exercises
- ☐ Toilet every ___ hours
- ☐ No fluids before bed
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____

Date: ____________________________________

Clinician Name ______________________________ Clinician Signature: ______________________________

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