Saskatchewan Pelvic Floor Pathway

Addressograph

MEDICAL HISTORY FORM

Instructions: Please complete this medical history form. Sign and date the bottom of each page in the space provided. The information provided by you will be treated as confidential.

Practitioner Comments:

1. Please describe the main problem you would like us to address and how long it has been a problem.
(for example "I leak urine on the way to the bathroom" or "I feel a bulge in my vagina")

2. What treatments have you already tried for your problem?

☐ nothing	☐ physiotherapy	☐ antibiotics
☐ lifestyle change (weight loss, caffeine reduction)	☐ pessary	☐ medication
	☐ surgery	☐ pelvic floor exercises

Details: (when, for how long, what were the results)

3. What do you hope to accomplish with further treatment?

4. Do you have any medical problems? (Check only those that apply to you.)

- ☐ high blood pressure
- ☐ bleeding problems
- ☐ abnormal bruising
- ☐ diabetes
- ☐ thyroid disease
- ☐ renal/kidney failure
- ☐ heart burn
- ☐ hiatus hernia
- ☐ stomach ulcers
- ☐ sexually transmitted infection (STI)

Mood disorders such as:
- ☐ depression
- ☐ anxiety
- ☐ bipolar disorder

Heart problems such as:
- ☐ angina
- ☐ heart attack
- ☐ rheumatic fever
- ☐ pacemaker
- ☐ heart murmur
- ☐ irregular heart beat

Breathing problems such as:
- ☐ asthma
- ☐ emphysema
- ☐ chronic bronchitis

Neurological conditions such as:
- ☐ stroke
- ☐ Parkinson's
- ☐ multiple sclerosis
- ☐ epilepsy/seizures

	Practitioner Comments:
Other medical conditions: (please give details)	
5. What was the date of your last full physical exam?	
Are you seeing other doctors, apart from the referring doctor? For what reasons?	
6. What was the date of your last eye exam? Do you have: ☐ glaucoma ☐ pain in the eyes ☐ halo around the eyes ☐ nearsightedness ☐ cataracts/cataracts removed	
7. List all operations: (Note any surgeries that you had and when you had them. Examples: appendectomy, hysterectomy, tubal ligation, gall bladder, cataract/eye surgery)	

Operation	Date (approximately)

8. To your knowledge, have you or any of your relatives ever had a problem with an anaesthetic?

☐ no ☐ yes Details:

9. To your knowledge, have you or any of your relatives ever had blood clots in the legs or lungs?

☐ no ☐ yes Details:

10. To your knowledge, have you or any of your relatives ever had cancer of the breast, uterus or ovaries?

☐ no ☐ yes Details:

11. Occupation: ____

What kind of work do you do in your job or household? (Examples: lifting & carrying, on my feet a lot, sitting at a desk, light housework, gardening, etc.)

12. Do you smoke? ☐ no ☐ yes Amount per day:

13. Childbirth history:

How many pregnancies have you had? ___________

How many children do you have? _____________

Weight of largest baby: ____________________

Any forcep or vacuum deliveries? ☐ no ☐ yes

Any caesarean deliveries? ☐ no ☐ yes

Any twins? ☐ no ☐ yes

Any episiotomies (cuts)? ☐ no ☐ yes

Any tears? ☐ no ☐ yes

14. Are you currently using contraception/birth control?

No. Why not? ☐ not sexually active ☐ not avoiding pregnancy
☐ currently pregnant ☐ past menopause ☐ lesbian partnership

Yes. What type? ____

15. History of physical, emotional or sexual harm ☐ no ☐ yes ☐ maybe

16. List any prescription medications you are taking (or attach a list)

17. List any over-the-counter medications you are taking:
(Example: vitamins, pain medication, cough syrup)

18. Are you allergic to any medications? (please list)

Name of medication:	Details of reaction:

19. Do you have any other allergies?
☐ no allergies ☐ latex ☐ metal ☐ other
Details of reaction:

Practitioner Comments:

Name (print): ______________________________ Date: ______________ Signature: _____________________

Thank you for providing this medical history information.