Your Pelvic Physio

GENERAL HISTORY - FEMALE

Please complete the following questions (where relevant) and bring the completed form to your first appointment. All information you provide is strictly confidential.

Name:..... **Age:**.....

Obstetric History: ☐ Please tick if not relevant

Date	Vaginal of Caesarean	Weight	Forceps	Episiotomy / tear

Are you currently breastfeeding? ☐ Yes ☐ No

Past Surgical History:

1. **Gynaecological surgery:**
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   .....
   .....
2. **Bladder or kidney surgery:**
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   .....
3. **Bowel surgery:**
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   .....
4. **Back surgery:**
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   .....
5. **Other surgery:**
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   .....

Have you been in hospital in the past year? ☐ Yes ☐ No

Medical History: Please Tick

	Diabetes		Chronic cough		Constipation/straining
	Heart disease		Asthma		Vaginal infections
	High blood pressure		Lung disease		Bladder infections
	Low blood pressure		Neurological disease		Pelvic organ prolapse
	Stroke		Osteoporosis		Heavy lifting
	Depression		Back injury		Prolonged standing
	Psychiatric illness		Arthritis		Hernia
	Cancer		Other *Please specify*		

Smoking History:

☐ Non-smoker ☐ Past ☐ Current: number of cigarettes per day .....

Current Medications: Please include any prescription and over the counter medications e.g. vitamin supplements, laxatives.

Medication	Dosage	Date started

Have you had any investigations or management of bladder or bowel or pelvic problems in the past? ☐ **Yes** ☐ **No**

If yes please provide details:

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Do you participate in any regular exercise? ☐ **Yes** ☐ **No**

If yes please provide details:

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Fluid Intake: Please list your usual fluid intake over a 24 hour period (cups or glasses).

Water	Tea	Coffee	Alcohol	Soft drink	Milk	Juice	Other

Thank you very much for completing this form. I look forward to meeting you at your first appointment.