Have you had any recent bladder or urinary tract infections? Yes___ No___
Fluid Intake in 24 hours: # cups coffee ___ water___ tea___ other fluids:_____
How much does leaking urine interfere with your everyday life?
(Not at all) 0 1 2 3 4 5 6 7 8 9 10 (A great deal)

Bowel History:

Frequency: ____x/week
Fecal Incontinence: Yes__ No__
Fecal Urgency: Yes___ No___
Constipation: Yes__ No__
Stool Consistency: Loose___ Soft/formed___ Hard___ Varies___

Pain History:

Do you have pelvic pain? Yes___ No___
If yes, what do you think is causing your pain? _____
Where do you feel your pain?_____
How long have you had pain? _____
Are you sexually active? Y___N___ Do you have pain with sexual activity? Y__ N__
If yes, with Penetration Y__ N__ Thrusting Y__N__ Deep Y___N___
How would you describe your pain?_____
What makes your pain Better?_____ Worse?_____
How strong would you rate your pain on average? 1 2 3 4 5 6 7 8 9 10
How intense was your worst pain during the past 4 weeks? 1 2 3 4 5 6 7 8 9 10

Medical History:

Abdominal Surgery:_____
Pelvic Surgery:_____
Medical Tests Completed:_____
Medical Treatments:_____
Do you exercise? _____
If yes, what do you do? _____
Do your symptoms prevent you from exercising? _____
Do you smoke? Yes___ No___ PPD____
Do you have a chronic cough? Yes___ No___

BIHC | Belleville Integrative Health Centre

WORKING TOGETHER FOR YOUR HEALTH

FEMALE SYMPTOM MONITOR

Name:_____ Age:_____ DOB: _____ Date:_____
Occupation: _____Did someone refer you to this clinic?_____

Reason for Assessment:
1._____
2. _____
3._____

Gynecological History:

Pregnancies: _____
live births:_____
Wt heaviest baby:_____lbs _____oz
Length pushing stage:____
Complications:_____
C-section births? Yes__ No__ #___
Age of children: _____
Forceps? Yes___ No___
Episiotomies? Yes_____ No___
Tears? Yes___ No___ Grade___
Last Pap: _____Normal?Y__N___
Vaginal Infections: _____
Sexually Transmitted Infections:_____

Birth Control Method:_____
Menstrual Cycle: None____
Regular Y__N__
Menopause: Yes___ No___
Age of onset:____
Symptoms:_____
Hormone Replacement? Y__N__
Do you feel heaviness or pressure in the vaginal area? Yes___ No___
Have you ever been told you have a prolapse? Yes___ _No___
Have you used a pessary? Yes__ No__

Bladder Symptoms:

Do you leak urine with activities such as coughing, sneezing, laughing or physical activity? Yes__ No__ How often? Daily__Weekly__ Volume: Lg__ Med___Sm ___
Do you leak urine after having an intense urge to urinate that feels uncontrollable? Yes__ No__ How often? Daily____ Weekly___ Large volume___ Small volume___
Do you leak at night? Yes___ No___
Other circumstances of leakage? _____
Urination frequency: Day: every _____ hours or ____x/day Night: _____ x/night
Do you feel you fully empty your bladder? Yes___ No___
Do you have to strain to urinate? Yes___ No___
Do you have pain with urination? Yes___ No___

Do you have strong sensations (urges) prior to voiding? Yes___ No___
Causes your urgency? Key in the door___ Cold___ Running water___ Others:____
Do you wear pads for incontinence? Y___ N____ if yes, # per day? ____