Eastside Women's Health Center

Pelvic Floor Therapy- Past Medical History Form

Name: _____Today's Date: _____

Age: _____ Date of birth: _____

What brought you in today? _____

First day of last menstrual period: _____ Are you pregnant? _____ Trying to conceive? _____

Date of last pelvic exam/PAP: _____ Results: _____ Date of abnormal PAP? _____

Number of Pregnancies: _____ Date/Type of deliveries (vag or cesarean)/Miscarriage/Abortion:_____

_____

Please list any abdominal or pelvic surgeries: _____

_____

Please list any types of birth control/length of time used: _____

_____

What are your goals for pelvic health? _____

_____

If you have now, or have had in the past, any of the following, please check and explain with dates:

___ low back pain _____

___ pelvic/abdom pain _____

___ menstrual pain/PMS _____

___ prolonged bleeding/altered cycles _____

___ pain during sex _____

___ sexually transmitted disease _____

___ fibroids/cysts _____

___ UTI/bladder infections _____

___ hemorrhoids _____

___ constipation/irritable bowel _____

___ tearing with birth/episiotomy _____

___ childbirth complications _____

___sexual abuse _____

___ physical/other abuse _____

___ depression _____

___ cancer _____

___ drug abuse _____

___ smoking habit _____

___ eating disorder _____

___ other relevant info you want to share _____

_____