KAREN BALAC PHYSICAL THERAPY, PLC

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HEALTH SCREENING QUESTIONNAIRE

Name _____ Date_____ Age_____

Circle any/all of the specific problems or conditions you now have or have ever had. Explain all yes responses below and include the date problem began.

Medical History

Y/N High blood pressure
Y/N Diabetes
Y/N Neurologic/Multiple Sclerosis
Y/N Stroke/Head injury
Y/N Allergies
Y/N Latex sensitivity or allergy
Y/N Smoking habit
Y/N Other please describe _____
Y/N Cancer (type)_____
Y/N Asthma/Emphysema/COPD
Y/N Heart disease
Y/N Broken bones/Joint problems
Y/N Low back pain/Sciatica
Y/N Sexually transmitted diseases
Y/N HIV/AIDS

Date of last pelvic/prostate exam _____ Date of urinalysis _____
Other tests_____

Surgical History

Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder
Y/N Surgery for your prostate
Y/N Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N Childbirth vaginal deliveries #_____
Y/N Episiotomy #_____
Y/N C-Section #____
Y/N Difficult childbirth #_____
Y/N Prolapse or organ falling out
Y/N Other /describe_____
Y/N Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? ____
Y/N Painful vaginal penetration
Y/N Pelvic pain

Bladder /Bowel

Y/N Trouble initiating urine stream
Y/N Childhood bladder problems
Y/N Constant dribbling of urine
Y/N Blood in urine
Y/N Urinary hesitancy/slow stream
Y/N Trouble feeling bladder urge/fullness
Y/N Dribbling after urination
Y/N Other/describe_____
Y/N Trouble emptying bladder completely
Y/N Recurrent bladder infections
Y/N Constipation/straining for movement
Y/N Trouble holding back gas/feces
Y/N Trouble feeling bowel/urge/fullness
Y/N Difficulty stopping the urine stream
Y/N Straining or pushing to empty bladder

Explain all yes responses_____
_____
_____
_____

Medication	Start date	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____