Women's Pelvic Health Medical History

At what age did you start menstruating? ____ Have you gone through menopause? Yes / No If yes, age _____

Are your cycles regular? Yes / No Explain: _____

Are you pregnant? Yes / No Do you use birth control? Yes / No Type: _____

Pregnancies: ____ Vaginal births: ____ Cesareans: ____ Episiotomies: ____ Perineal tears: ____ Level: ____

Do you have or have you ever had:

___Pain or other symptoms with menses/ovulation? Explain: _____

___Premenstrual symptoms (describe):_____

___Problems/injuries related to pregnancy: _____

___Increased ___decreased frequency of urination How many times/day? ___ How many times/night? ____

___Increased ___decreased frequency of BM How many times/day? ___ How many times/night? ____

___Urine leakage with:

___sneezing
___coughing
___laughing
___intercourse
___running/jumping
___putting a key in a door
___hearing running water
___the urge to urinate
___other_____

___Pelvic pain (describe):_____

___Premenopausal symptoms (describe):_____

___Pain with urination, bowel movement or intercourse

Do you have any of the following?

___retroverted uterus
___fibroids/tumors
___endometriosis
___ovarian cysts
___pelvic inflammatory disease
___interstitial cystitis
___osteopenia
___osteoporosis
___pudendal neuralgia

Are you taking any medications, herbs or supplements for hormone replacement? Yes / No If yes, please list:

_____
_____
_____
_____