INFORM
PHYSIOTHERAPY
PILATES | WOMEN & MEN'S HEALTH | MASSAGE

GENERAL HEALTH INFORMATION FORM FOR MEN

Please complete both sides of this form regarding your past and current personal, medical and surgical history, on.

Name:______________________________Date:__________

Date of birth:______/_____/________ Age:______________

Exercise Routine: ☐ Regular ☐ Irregular
Describe:______________________________

____

Past Surgical History: *(Please record date if recalled)*

1. Bladder (e.g. prostate):

____

2. Bowel:

____

3. Kidney:

____

4. Back (spine):

____

5. Other Surgery:

____

Medical Conditions: *(Past and/ or current, please tick one or more as appropriate. Please indicate how long the condition has been a problem for)*

Diabetes__________________☐ Heart disease/condition__________________☐

High Blood Pressure__________________☐ Lung disease/condition__________________☐

Osteoporosis__________________☐ Neurological condition__________________☐

Depression/Anxiety__________________☐ Incontinence (bladder/bowel)__________________☐

Back Problems__________________☐ Arthritis__________________☐

Stroke__________________☐ Bladder Infections__________________☐

Constipation/straining__________________☐ Hernia__________________☐

Other (please specify):______________________________

____

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Smoking status: ☐ Current ☐ Past ☐ Never

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

If yes, please specify reasons & for how long?____

____

Medications: *Please list your current medications (including vitamins, or any product you take for bladder / bowel) and dosages. If recalled, please state approximately when you commenced the medication.*

Medication	Dosage	Date commenced

Previous investigation or management of Bladder or Bowel problems:

☐ Nil ☐ Specialist referral ☐ Past surgery (record details on page 1)

☐ Investigations: please specify results if known *(eg: bladder or bowel tests, scans etc)*

____

☐ Previous medication: if yes, please specify what, when, and the effect on symptoms:

____

☐ Previous Physiotherapy: if yes:

☐ Individual Assessment ☐ Group/Class ☐ Verbal instruction

☐ Other therapy: if yes, please specify ____