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

GENERAL HEALTH INFORMATION FORM FOR WOMEN

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

Name:_____Date:_____

Date of birth:_____/_____/_____ Age:_____

Obstetric: Number of pregnancies (beyond 24 weeks):_____

Date Dd/mm/yr	Vaginal of Caesarean	Baby's Weight	Forceps/ Vacuum	Episiotomy/tear	Length of pushing stage

Exercise Routine: ☐ Regular ☐ Irregular

Describe:_____

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

1. Bladder (e.g. colposuspension / sling etc):
2. Gynaecological (e.g. hysterectomy / prolapse repair):
3. Bowel (inc anal sphincterotomy, haemorrhoidectomy):
4. Kidney :
5. Back (spine):
6. Other Surgery:

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

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_____ ☐ Incontinence (bladder/bowel)_____ ☐

Back Problems_____ ☐ Arthritis _____ ☐

Vaginal infections (thrush)_____ ☐ Bladder Infections_____ ☐

Constipation/straining_____ ☐ Pelvic organ prolapse_____ ☐

Other (please specify):_____

_____

_____

Smoking status: ☐ Current ☐ Past ☐ Never

Medications: *Please list your current medications (including hormone replacement therapy (HRT), 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

Hormonal Status: ***Are you currently:***

Pregnant: ☐ No ☐ Yes Date due:_____

Menstruating regularly ☐ No ☐ Yes

Peri-menopausal ☐ No ☐ Yes

Post-menopausal ☐ No ☐ Yes Age at end of menopause:_____

Previous investigation or management of Bladder, Bowel or Pelvic 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 _____