CAROLINA PELVIC HEALTH CENTER, INC.

PATIENT HISTORY

Name (First, Middle,Last) _____ Date _____

Primary care physician _____ Referring physician _____

Emergency Contact _____ Relationship _____ Phone _____

Preferred pronouns (circle one) she/her/hers he/him/his they/them other_____

How did you hear about us? (Check all that apply)

Doctor/Medical Provider_____ Google_____ Instagram_____Facebook_____

Reddit_____ Friend _____ Other_____

HEALTH HISTORY

General Health (circle one): *Excellent* *Good* *Average* *Fair* *Poor*

Have you had any major life changes in the past year? Y/ N

If yes, please explain: _____

Current stress level: *High* *Medium* *Low* Current counseling/ therapy? Y/ N

Occupation: _____ On disability/ leave: Y/ N Restrictions? _____

Activity/ Exercise: *None* *1-2 days/ week* *3-4 days/ week* *5+ days/ week*

Please describe:_____

Do you currently smoke or use tobacco? Y/ N

Since the onset of your current symptoms have you had:

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness or fainting
Y/N Change in bowel or bladder functions
*Y/N Other/describe*_____
Y/N Malaise (Unexplained tiredness)
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness / Tingling

Date of last physical exam: _____ Tests performed _____

_____

FAMILY HISTORY (Circle and list relationship to you, and age of onset)

Heart disease _____ *High blood pressure* _____ *Stroke* _____

Diabetes _____ *Cancer* _____ *Other* _____

MEDICAL HISTORY (Circle all that apply)

Cancer
Heart problems
High Blood Pressure
Ankle swelling
Anemia
Low back pain
Sacroiliac/Tailbone pain
Alcoholism/Drug problem
Childhood bladder problems
Depression
Anorexia/bulimia
Smoking history
Vision/eye problems
Hearing loss/problems
Stroke
Epilepsy/seizures
Multiple sclerosis
Head Injury
Osteoporosis
Chronic Fatigue Syndrome
Fibromyalgia
Arthritic conditions
Stress fracture
Rheumatoid Arthritis
Joint Replacement
Bone Fracture
Sports Injuries
TMJ/ neck pain
Emphysema/chronic bronchitis
Asthma
Allergies-list below
Latex sensitivity
Hypothyroid/ Hyperthyroid
Headaches
Diabetes
Kidney disease
Irritable Bowel Syndrome
Hepatitis HIV/AIDS
Sexually transmitted disease
Physical or Sexual abuse
Raynaud's (cold hands and feet)
Pelvic pain

Additional information: _____

SURGICAL HISTORY (include details/date)

Y/N Back/ Spine _____ Y/N Bladder/prostate_____
Y/N Brain _____ Y/N Bones/joints_____
Y/N Gynecologic _____ Y/N Abdominal organs _____
Other/describe_____

Pelvic Health

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 Vaginal dryness
Y/N Painful periods
Y/N Menopause - when? _____
Y/N Painful vaginal penetration
Y/N Pelvic pain Y/N Other /describe

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Y/N Other /describe _____

MEDICATIONS (prescription/over the counter) **Start date** **Reason for taking**

_____
_____
_____

What are your symptoms:

_____
_____

What are your goals of treatment:

_____
_____