First Coast REHABILITATION
where patient care comes first

WOMEN'S HEALTH MEDICAL HISTORY

Patient Name:	Age:	Date:

How did you hear about First Coast Rehabilitation? _____

Have you previously received services from First Coast Rehabilitation? ☐ Yes ☐ No

Please state your diagnosis as told to you by your physician: _____

Have you ever, or are you presently being treated for any of the following problems?
PLEASE CHECK THE APPROPRIATE BOX.

Heart Trouble	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Back Injury	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Bleeding Disorder	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐	Fracture	Yes ☐	No ☐
Fainting Spells	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Metalology (implants)	Yes ☐	No ☐
Pregnancy	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Allergies	Yes ☐	No ☐
Pelvic Pain	Yes ☐	No ☐	Fibromyalgia	Yes ☐	No ☐
Pelvic Inflammatory Disease	Yes	No	Chronic Fatigue Syndrome	Yes ☐	No ☐
Rectal Pain	Yes ☐	No ☐	Endometriosis	Yes ☐	No ☐
Pain with intercourse	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Fibroids	Yes ☐	No ☐	Pelvic/Vulvar pain	Yes ☐	No ☐
Bleeding Disorder	Yes ☐	No ☐	Hip pain	Yes ☐	No ☐
Bowel problems	Yes ☐	No ☐	Leg cramps	Yes ☐	No ☐
Diet Restrictions	Yes	No	Other		

Date of injury: _____ How did the injury occur: _____

_____

Work related or recreational activities you participate in regularly _____

Have you been hospitalized for the present problem? Yes ☐ No ☐ If so, when? _____

Have you had surgery for the present problem? Yes ☐ No ☐ If so, when? _____

Have you received previous treatment for this problem? Yes ☐ No ☐ If so, when? _____

If yes, please summarize the results: _____

_____

List your usual recreational activities/exercise. _____

_____

Check Previous Surgeries:

Hysterectomy: abdominal ___ vaginal ___ ovaries removed ___

Hernia Repair ___ C-Section ___ Appendectormy ___ Gallbladder ___

Kidney Surgery ___ Bladder repair ___ Back/Neck Surgery ___ Prostate ___

Other _____

Hormone Replacement Therapy Yes / No ☐ (Circle) Pill Patch Cream Estrogen Progesterone

If so, when? _____

Obstetric History: Number of Children ____,

If pregnant, due date: _____, # weeks gestation _____, # of previous pregnancies _____

# of Vaginal deliveries _____, # C-Sections _____, # Episiotomies _____

Complications this or prior pregnancies? _____

Level of exercise prior to pregnancy? _____

Painful Episiotomy Scar? Yes / No Other painful incisions? _____

Bladder Habits (Please check all that apply):

___ Frequent Urinary Tract Infections
___ Strong urge to urinate produces involuntary loss
___ Loss of urine on the way to bathroom
___ Loss of urine arriving at bathroom
___ Urgency if cold or hear running water
___ Loss of urine with cough/sneeze/lifting/ exercise
___ Difficulty initiating urine stream
___ Difficulty stopping urination
___ Burning with urination
___ Pain with urination
___ Blood in urine

# of Voids/day ____ # of Voids/night ____ # Episodes Involuntary urine loss/day ____

Amount of Lost: small ____ large ____ Few drips ____ Continuous dribbling ____

Bed wetting? Yes / No Do you use protective devices? Yes / No # of pads/day

Do you restrict fluid intake because of urinary leakage? Yes / No

cups of caffeinated and/or carbonated beverages/day ____, # cups of water/day ____, # cups of juice/day ____

Have you ever taken medication(s) to prevent urine loss? Yes / No

Bowel Habits:

Do you have any gastrointestinal disease? Yes / No _____

Are you frequently constipated? Yes / No If so, how do you resolved this? High Fiber Diet ___, Laxatives ___, Enemas ___

Do you frequently have diarrhea? Yes / No

Do you notice blood in your stool? Yes / No Often? Yes / No Hemorrhoids? Yes / No

Rectal pain? Yes / No If yes: At rest ___, Sharp ___, Fleeting Pain ___ With bowel movement ___

Is there currently any other health, medical, or chiropractic services being rendered to you by any other agency, organization or individual, including home health? Yes ☐ No ☐

If yes, please explain: _____

_____

Last seen by Physician (Date): _____ Next appointment with Physician: _____

Are you on any medications? Yes ☐ No ☐ If yes, please state TYPE of medication: _____

Have you ever had any of the following (check all that apply):

☐ EMG ☐ CAT SCAN ☐ MYELOGRAM ☐ X-RAY ☐ MRI

Have you ever received Physical Therapy, Occupational Therapy, or Speech Therapy services elsewhere?

Yes ☐ No ☐ If yes, where, when, and why: _____

_____

I believe the above to be true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____