CAROLINA PELVIC HEALTH CENTER, INC.

Patient History

Name (Last, First, Middle) _____ **Date**_____

Primary care physician _____ **Referring Physician** _____

Emergency Contact _____ **Relationship** _____ **Primary Phone** _____

How did you hear about us?

Doctor_____ **Internet**_____ **Carolina Woman**_____ **Radio**_____ **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	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe_____		

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

WOMEN ONLY

Y/N	Childbirth vaginal deliveries #____	Y/N	Vaginal dryness
Y/N	Episiotomy #___	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? ___
Y/N	Difficult childbirth #_____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe_____		

MEN ONLY

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

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

_____
_____
_____
_____