Lizanne Pastore PT, MA, COMT

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name:_____ _____**Why are you here?**_____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	**MEDICAL PROBLEMS**	√	***CHILDBEARING HISTORY***	
Heart Disease/Surgery		Diabetes		Are you Pregnant? Yes No If yes, what is your due date:_____	
High Blood Pressure		Melanoma		# of Children (circle one number)	0 1 2 3 4 5 +
Pain/tightness in chest		Cancer		# of Vaginal deliveries (circle)	0 1 2 3 4 5 +
Cold Hands		Dizziness		# of C-Sections (circle one number)	0 1 2 3 4 5 +
Cold Feet		Thyroid Problems		# of episiotomies (circle one number)	0 1 2 3 4 5 +
Numbness in hands/feet		Falls the last 6 mos.		# of forceps deliveries	0 1 2 3 4 5 +
		# trips/slips/near falls			
BONES & JOINTS		Depression		***GYNECOLOGICAL HISTORY***	
Chronic Fatigue Syndrome		Lupus		Date of Last Pap Smear:	
Arthritis				History of Yeast Infections	Yes No
Fibromyalgia		**LUNG/BREATHING**		History of Candida	Yes No
Tailbone pain		Shortness of Breath		History of Genital Herpes	Yes No
		Smoke cigarettes now		Do you have any current infections or yeast	Yes No
AREAS OF PAIN		History of smoking		Do you use Bath salts	Yes No
Back				Do you use vaginal foams, sprays, deodorants	Yes No
Neck/shoulders		**SURGICAL HISTORY**		Do you use a spermicide	Yes No
Rectal area		Back or neck		Do you use vaginal lubricants?	Yes No
Abdomen/belly		Tubal Ligation		Do you use latex condoms	Yes No
Vagina		Laproscopy		Do you use KY jelly vaginally	Yes No
Vulvar Tissue		Abdominal Hysterectomy			
ALLERGIES		Vaginal Hysterectomy		***URINARY/BLADDER HISTORY***	
Ragweed		Gall Bladder		Do you urinate more than once every 2 hours?	Yes No
Food allergies		Bladder surgery		Do you have a sense of "urgency" to urinate?	Yes No
Latex allergies		Pelvic Surgery		Do you have symptoms of leaking urine	Yes No
Seasonal Allergies		Vaginal Surgery/laser		Do you have interstitial cystitis	Yes No
SKIN CONDITIONS		Vulvar Surgery			
Eczema				***BOWEL HISTORY***	Yes No
Contact Dermatitis		**FAMILY HISTORY**		Do you have Irritable Bowel Syndrome	Yes No
Psorasis		Skin cancer		Do you leak gas or feces	Yes No
Lichens Simplex		Allergies		Do you have constipation	Yes No
Other					

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: __Single __Married ___Separated __Divorced ___Dating

Do you feel safe at home? ___Yes ____ No Comment:_____

Occupation:_____ Physically this means I ___sit ___stand __walk most of the day

Educational Level _____ **Hobbies**: _____ _____

EXERCISE HISTORY:
___No exercise ___Walk _____ ____Go to gym _____

Other_____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	√		√		√		√		√		√		√
Happy →		Calm →		Unmotivated		Stressed		Lonely		Content		Depressed	
Overwhelmed →		Sad →		Tired		Afraid		Energetic		Optimistic		"Postpartum blues"	
Flabby →		Strong →		Un-rested		Lethargic		Weak		Overworked		Not bonding with baby(ies)	
Anxious →		Unsafe →		Abused		Neglected							

HOW DO YOU LEARN?: ___Listening (lecture, discussion) ___Seeing (read, video, DVD) __Doing (practicing skill)

Is English your primary language? ___Yes ____No. If no, would you need a translator when you are in therapy? _____

NUTRITION: How much do you weigh? _____pounds

Would you like to ___lose or ____gain weight?	Yes No	
Have you gained/ lost more than 10 pounds in the last year?	Yes No	
Are you on any special diet?	Yes No	__Low Carb ___Atkins ___South Beach __Weight Watchers __Diabetic __Other_____
Would you say your diet is "unhealthy"?	Yes No	__too many fast foods __Not enough vegetables __High Fat __High Carb __Other_____

FLUID INTAKE: What do you drink every day?
____8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer
____glasses of wine ___glasses of liquor ___ 8-ounce glasses of milk ____8-ounce glasses of juice_____
____Other_____

Anything else you would like us to know about you?_____

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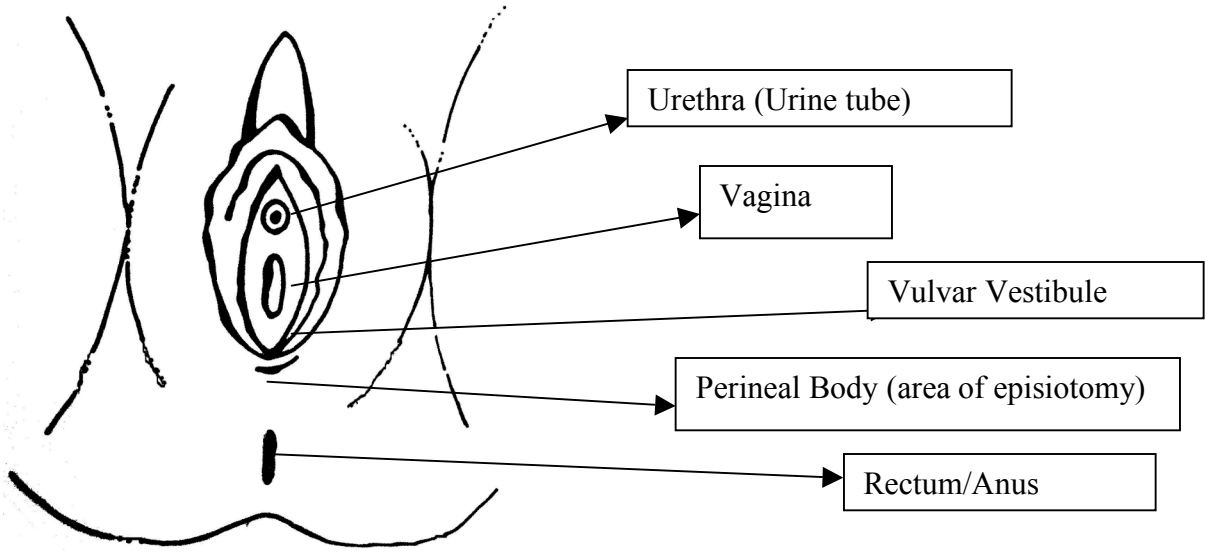
TELL US ABOUT YOUR VULVAR AND VAGINAL PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain



CURRENT SEXUAL ACTIVITY:

____Sexually Inactive due to PAIN ___Sexually inactive for other reasons ___Sexually active

<u>If you are sexually active, continue with this section.</u>

____No pain with intercourse ___Pain with intercourse, able to complete sex __ Pain with intercourse disrupts or prevents sex
____Pain with intercourse prevents any attempt to have sex ___ Tolerate manual or oral stimulation only/no penetration

CHECK THE WORDS THAT DESCRIBE YOUR PAIN:

___Hot ____Burning ___Scalding ___searing ___Sharp ___Cutting ___ Tearing ___Other_____
___Tiring ___Exhausting ___frightful ___punishing __grueling ___suffocating __ sickening ____Other_____
___Annoying ___Troublesome __miserable ___intense ___unbearable __discomforting ___Other_____

WHAT MAKES YOUR PAIN BETTER:

____Heating pad ___Ice pack ___Resting in bed ___Resting in Chair ___Medication ___Cream _____
____Abstaining from sexual intercourse ___Not using tampons ___Not wearing tight clothes ___other_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Surgery	Yes No A little
Treatment for Yeast (describe treatment)	Yes No A little	Physical Therapy	Yes No A little
		Other	Yes No A little

What started this problem? _____

INDICATE THE LEVEL OF DIFFICULTY YOU HAVE WITH THE FOLLOWING ACTIVITIES USING THE KEY BELOW:
0=*No problem,* ***1***= *very small problem* ***2***=*Small problem* ***3***= *medium problem* ***4***=*Big Problem or* ***NA***

Measures for Vaginal Pain/Sensation	0	1	2	3	4	NA
Example: Able to insert tampon (small)			√			
Able to allow penetration into vagina by penis or similar size vibrator.						
Able to insert tampon: slender, medium, super						
Able to remove tampon without pain/discomfort						
Able to wear sanitary pads						
Physician is able to insert speculum for pelvic exam						
Able to insert index finger in vagina (partner or self)						
Able to tolerate wearing underwear						
Friction with clothing						
Burning in the vaginal and/or vulvar area						
Able to tolerate touch for sexual pleasure (manual, oral or vibrator)						
Painful urination after sexual intercourse						
Measures for Sitting						
Sitting 0- 15 minutes						
Sitting 16 – 60 minutes						
Sitting 1 -2 hours						
Sitting 2 – 4 hours						
Effect of Problem on Daily Life						
Affects choice of clothing (can't wear tight crotch)						
Walking short distances						
Walking long distances						
Exercise in gym or ride bike						
Ability for light housework						
Ability for heavy housework						
Ability to travel for work						
Ability to travel for longer than 2+ hours						
Interferes with social activity (movies, socializing)						
Interferes with my sex life						
Negatively impacts relationship with my partner						
Negatively impactsinteraction with family & friends						
Feelings of ___depression ___anxiety ____embarrassment ____frustration ____anger						
Pain impairs my ability to concentrate/function						
Pain impairs my ability to work "normal" hours						