CITY PHYSICAL THERAPY, PC

Women's Health Medical History Form

Name: _____ Referring Doctor: _____

CURRENT CONDITION

Please briefly describe your current condition: _____

Please check any of the following healthcare providers that you have seen related to this injury/condition:

☐ Primary Care Doctor ☐ Obstetrician ☐ Gynecologist ☐ Physiatrist (PMR)
☐ Orthopedist ☐ Massage Therapist ☐ Acupuncturist ☐ Other: _____

Have you received a gynecology exam within the last year? ☐ Yes ☐ No
Have you received surgery for you current injury/condition? ☐ Yes ☐ No
If yes, please indicate the date/type of surgery: _____

GENERAL MEDICAL HISTORY

Are you currently pregnant? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
If yes, please indicate the number of pregnancies (P) or miscarriages (M) you've had. (P) ____ (M) ____
Please indicate the number of vaginal (V) or Cesarean (C) deliveries if applicable. (V) ____ (C) ____

Are you currently on birth control? ☐ Yes ☐ No If yes, please indicate the type: _____
Do you experience pain with menstrual cycles? ☐ Yes ☐ No
Do you participate in penetrative intercourse? ☐ Yes ☐ No
Do you experience pain with intercourse? ☐ Yes ☐ No If yes, please briefly describe pain: _____
Do you experience incontinence? ☐ Yes ☐ No If yes, please indicate when/how: _____

Please check any and all conditions you currently have, or have been diagnosed with in the past.

☐ Do you have a pacemaker ☐ Yes ☐ No
☐ Cancer If yes, please specify type and date diagnosed: _____
☐ Infectious Disease If yes, please specify: _____

☐ Heart Disease ☐ High Blood Pressure ☐ Pre-eclampsia ☐ Endometriosis
☐ Polycystic Ovary Syndrome ☐ Osteoporosis/Osteopenia ☐ Diastasis Recti ☐ Hernia
☐ Kidney Problems ☐ Liver Problems ☐ Thyroid Problems ☐ High Cholesterol
☐ Diabetes ☐ Irritable Bowl Syndrome ☐ Hearing Difficulties ☐ Vision Difficulties
☐ Asthma ☐ Epilepsy/Seizure Disorder ☐ Chemical Dependency (i.e. alcoholism) ☐ Depression
☐ Other Surgeries: _____
☐ Other Medical Conditions: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs/day? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/week? _____

MEDICATIONS

Please list any medications/vitamins/herbs/supplements you take regularly, and the dosage.

Type: _____ Dose: _____ Type: _____ Dose: _____
Type: _____ Dose: _____ Type: _____ Dose: _____

RECREATIONAL ACTIVITIES

Please indicate the type and frequency of recreational activities that you participate in.

Type: _____ Frequency: _____ Type: _____ Frequency: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Contact: _____

Patient Signature: _____ Date: _____