PELVIC FLOOR HISTORY

NAME: _____

Date of last pelvic exam/PAP: ___/___/___ Results: _____

List dates of all positive PAP: _____

Pease list any pelvic or abdominal surgeries: _____

Please list types of birth control and length of time utilized: _____

_____

OBSTETRIC/PREGNANCY HISTORY

Date of Delivery	Vaginal or Cesarean	Complications

COMORBIDITIES

Please check any of the following conditions that you have now or have had in the past and provide dates:

_____ Low back pain _____

_____ Menstrual pain/PMS _____

_____Pain during sex _____

_____ Fibroids/Cysts_____

_____ Hemorrhoids_____

_____Tearing during birth_____

_____Sexual Abuse _____

_____Depression _____

_____ Drug Abuse_____

_____ Eating Disorder_____

_____ Pelvic abdominal pain _____

_____ Prolonged bleeding/altered cycles _____

_____Sexually transmitted diseases _____

_____ UTI/Bladder infections_____

_____ Constipation/Irritable Bowel_____

_____Physical Abuse _____

_____Cancer _____

_____Smoking Habit_____

_____Other_____

_____Other_____