# 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 |
| Rectum | | 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 | |
| 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

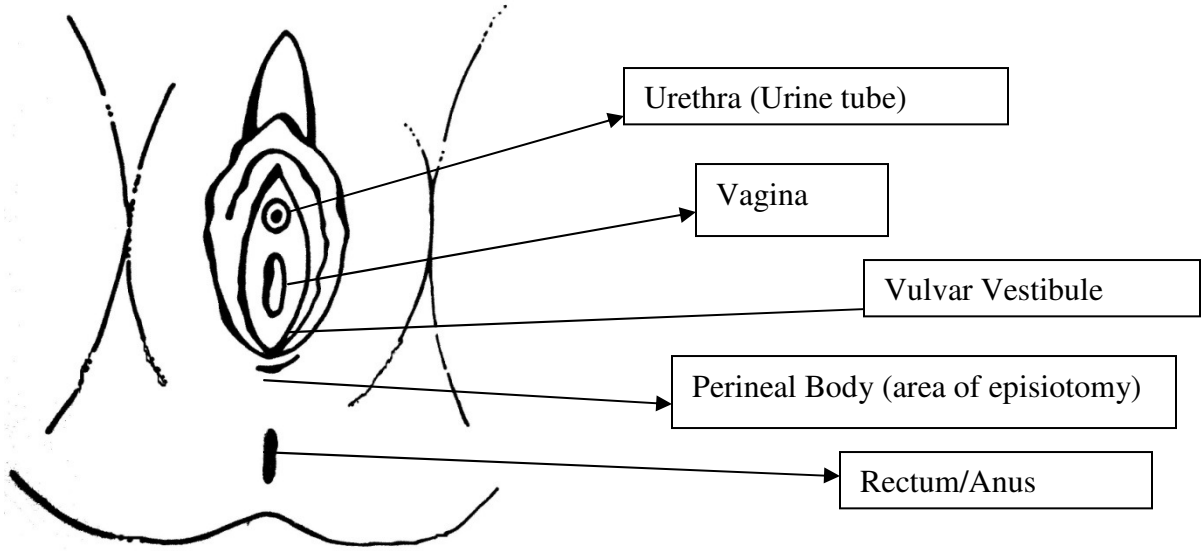
| | | |
|---|---|---|
| Would you like to ___lose or ____gain weight? | Yes No | |
| Have you gained/ lost more than 10 pounds in the last year? | Yes No | |
| Are you on any special diet? | Yes No | __Low Carb ___Atkins ___South Beach __Weight Watchers __Diabetic __Other_____ |
| Would you say your 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?_____

## *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 ALL THE ACTIVITIES THAT CAUSE OR INCREASE YOUR PAIN:**

___Gynecological Examination with Speculum ___Urination after intercourse ___Finger insertion into vagina
___Tampon insertion ___Tampon removal __Partner manual stimulation __Friction with clothing __Sports activity
___Urination in general __Oral stimulation by partner ___Masturbation alone __ Wearing pads
___Other_____

**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? _____

# VULVAR PAIN FUNCTIONAL QUESTIONNAIRE (V-Q)

These are statements about how your pelvic pain affects your everyday life. Please check one box for each item below, choosing the one that best describes your situation. Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment. Your responses will be kept completely confidential at all times.

1. Because of my pelvic pain
___3 I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.
___2 I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.
___1 I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.
___0 I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain
___3 Gets worse when I walk, so I can only walk far enough to move around in my house, no further.
___2 gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
___1 Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk loner distances for fun or exercise.
___0 My pain does not get worse with walking; I can walk as far as I want to
___0 I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain
___3 Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
___2 Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
___1 Occasionally gets worse when I sit, but most of the time sitting is comfortable.
___0 My pain does not get worse with sitting, I can sit as long as I want to.
___0 I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills I take for my pelvic pain
___3 I am sleepy and I have trouble concentrating at work or while I do housework.
___2 I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
___1 I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
___0 I don't have any problems with the pills that I take for pelvic pain.
___0 I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain
___3 I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
___2 It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
___1 Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
___0 It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
___3 I don't get together with my friends or go out to parties or events.
___2 I only get together with my friends or go out to parties or events every now and then.
___1 I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
___0 I get together with friends or go to events whenever I want, pelvic pain does not get in the way.

7. Because of my pelvic pain
___3 I can't stand for the doctor to insert the speculum when I go to the gynecologist.
___2 I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
___1 It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
___0 It never hurts for the doctor to insert the speculum when I go to the gynecologist.

8. Because of my pelvic pain
___3 I cannot use tampons at all, because they make my pain much worse.
___2 I can only use tampons if I put them in very carefully.
___1 It usually doesn't hurt to use tampons, but occasionally it does hurt.
___0 It never hurts to use tampons.
___0 this question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.

9. Because of my pelvic pain
___3 I can't let my partner put a finger of penis in my vagina during sex at all.
___2 My partner can put a finger or penis in my vagina very carefully, but I still hurts.
___1 It usually doesn't hurt if my partner put a finger or penis in my vagina , but every now and then it does hurt.
___0 It doesn't hurt to have my partner put a finger or penis in my vagina at all.
___0 This question does not apply to me because I don't have a sexual partner.
___0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

10. Because of my pelvic pain
___3 It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.
___2 My partner can touch me sexually outside the vagina if we are very careful
___1 It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt.
___0 it never hurts for my partner to touch me sexually outside the vagina
___0 This question does not apply to me because I don't have a sexual partner
___0 Specifically, I wont get involved with a partner because I worry about pelvic pain during sex.

11. Because of my pelvic pain
___3 It is too painful to touch myself for sexual pleasure.
___2 I can touch myself for sexual pleasure if I am very careful.
___1 It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.
___0 It never hurts to touch myself for sexual pleasure.
___0 I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.