PELVIC EXAMINATIONS CONSENT FORM

Patient Name: _____

Date of Birth: _____

****

- **CONSENT:** I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician or other health care practitioner, any medical student or any student receiving training as a health care practitioner.

- **NATURE OF PELVIC EXAMINATIONS:** For the purposes of this Consent Form, a "pelvic examination" means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissue, or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

- **VALIDITY OF CONSENT:** The Patient, or the Patient's legally authorized person, acknowledges that this consent will remain valid from the date the Patient, or the Patient's legally authorized person, dated this Consent Form below, unless otherwise revoked in writing by the Patient, or the Patient's legal authorized person.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Patient's Signature Date

_____ _____
Legally Authorized Person Signature Relationship to Patient

_____ _____
Legally Authorized Person Printed Name Date

_____
Witness Signature

_____ _____
Witness Printed Name Date

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Height: _____ Weight_____ Chief Complaint: _____

When did your symptoms start? _____

What do you think caused your symptoms? _____

How many physicians have you seen regarding this problem? _____

What treatments have you received (medications, therapy, surgery, etc.)? _____

Are you currently receiving Home Health Services? ❑ Yes ❑ No If yes, explain _____

How much is your problem affecting your quality of life, 0-10 (0 = no effect and 10 = severe impairment)? _____

Pelvic/Abdominal History

	Yes	No		Yes	No
Kidney Infection			Interstitial Cystitis		
Pelvic Pain			Kidney Stones		
Pelvic or Abdominal Adhesions			Hormonal Problems		
Cysts			Abdominal Problems		
Intestinal Problems			Digestive Problems		
Chronic Fatigue			Hemorrhoids		
Incontinence			Uterine Fibroids		
Vaginal Infection			Endometriosis		
Pelvic Inflammatory Disease (PID)			Constipation		
Painful Intercourse			Neurological Disorder		
STD or Herpes			Polyps		
Vaginal Dryness			Other:		

Pelvic/Abdominal Surgical History (i.e. hysterectomy, adhesions, endometriosis, etc.)

1. _____ Date: _____
2. _____ Date: _____

Date of most recent pelvic exam: _____

What form of birth control do you use? _____

Age when you had your first period? _____ Date of your last period: _____

How often do you have a period (in days)? _____ On average, how long does your period last (in days)? _____

What other symptoms do you experience with your period? _____

Are you sexually active? ❑ Yes ❑ No If No, ❑ Inactive due to PAIN ❑ Inactive - other reasons

Pregnancy / Labor & Delivery History (if applicable): ❑ NA

How many pregnancies have you had? _____ Vaginal births? _____ C-Sections? _____

Please list any complications with labor: _____

Did you tear during childbirth? ❑ Yes ❑ No If yes, how many times? _____

Infertility Issues (if applicable): ❑ NA

How many tubal pregnancies? _____ How many miscarriages? _____ Have you had any abortions? _____

Have you ever been told that you are infertile? ❑ Yes ❑ No If yes, how many times? _____

Are you undergoing any treatment for infertility? ❑ Yes ❑ No If yes, explain? _____

Name: _____ DOB: _____

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Bladder Symptoms (if applicable): ❑ NA

How many times do you urinate during the day? _____ During the night? _____

ICIQ-UI short form: circle your answer

A. *How often do you leak urine?* 0 never 1 about once a week or less often 2 2 or 3 times a week 3 about once a day 4 several times a per day 5 all the time	*When does urine leak? Check your answers* ❑ Never- urine does not leak ❑ Leaks before you can get to toilet ❑ Leaks when you cough or sneeze ❑ Leaks when you are asleep ❑ Leaks when you are physically active/exercising ❑ Leaks when you finished urinating and are dressed ❑ Leaks for no obvious reason ❑ Leaks all the time
B. *We would like to know how much urine you think leaks. How much urine usually leaks (whether you wear protection or not)?* 0 None 2 a small amount 3 a moderate amount 6 a large amount	*How many pads do you use?* 0 I do not use any pads or panty liners 1 I only use pads during certain activities 2 I use 1 pad per day 3 I use 2-4 pads per day 4 I use more than 4 pads per day 5 I use absorbent undergarments.
C. *Overall, how does leaking urine interfere with your everyday life? Choose a number between 0 (not at all) and 10 (a great deal)* (Not at all) 0 1 2 3 4 5 6 7 8 9 10 (a great deal)	
/ 21 = Sum scores from box A + B + C	

Bowel Habits:

Do you have a history of constipation? ❑ Yes ❑ No

Do you have any fecal leakage? ❑ Yes ❑ No

If yes, how are you managing (pads, etc.)? _____

How often do you have a bowel movement? Per Day? _____ Per Week? _____ Consistency (hard, soft)? _____

Do you experience pain before, during, or after a bowel movement? ❑ Yes ❑ No

Do you have anal fissures of hemorrhoids? ❑ Yes ❑ No

Does anything make your bowels better or worse? _____

Are you currently taking anything (i.e. stool softeners, laxatives)? ❑ Yes ❑ No If yes, what: _____

What is your daily fluid intake? _____

Have you made any dietary changes? ❑ Yes ❑ No

If yes, what type: _____

Name: _____ DOB: _____

MRN: _____ FIN: _____

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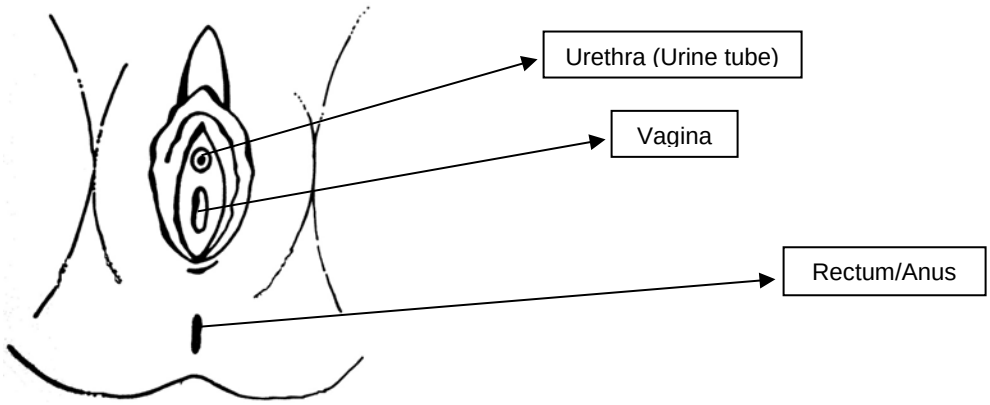
Vulvar & Vaginal Pain (if applicable): ❑ NA Please mark with an "X" where your pain begins. Shade any other areas of pain



Where is your pain located: _____

How does your pain change during a 24 hour period: _____

Morning: _____

Evening: _____

Night: _____

Any changes relating to activity? ❑ Yes ❑ No If yes, what are the patterns? _____

_____

What activities does pain interfere with/ prevent you from doing? _____

Describe your pain on a good day: _____

Describe your pain on a bad day: _____

Mark ALL the activities that cause or increase your pain

- ❑ Menstruation
- ❑ Wearing pads
- ❑ Finger insertion into vagina
- ❑ Oral stimulation by partner
- ❑ Gynecological Examination with Speculum
- ❑ Tampon removal
- ❑ Friction with clothing
- ❑ Partner manual stimulation
- ❑ Masturbation alone
- ❑ Tampon insertion
- ❑ Sports activity
- ❑ Urination after intercourse
- ❑ Urination in general
- ❑ Other: _____

Falls Risk Assessment

	Yes	No	
Are you seeing a physician for dizziness or imbalance?	___	___	
Do you have loss of balance or require assistance when getting up from sitting?	___	___	
Do you have difficulty walking without holding onto furniture or walls?	___	___	
Do you use an assistive device for walking (i.e. cane, walker, wheelchair)?	___	___	List: _____

How many times have you fallen in the last 3 months? _____

When/how did you last fall? _____

Appointment Guidelines

* If you are more than 10 minutes late, you may be asked to reschedule
* Cancellations and requests for rescheduling must be given 24 hours before the appointment time
* If you cancel more than 3 appointments or you do not show for more than 2 appointments within 10 scheduled sessions for any reason, you will automatically be removed from the therapy schedule and may be discharged. To restart therapy, you will need a new prescription from your physician. **Initial** _____

Name: _____ DOB: _____

MRN: _____ FIN: _____

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DIAGNOSIS: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Medical History:	Yes	No		Yes	No		Yes	No
ALS			Fevers			Reflux Disease/Heartburn		
Anemia			Fibromyalgia			Severe or Frequent Headache		
Arthritis			Gout			Shortness of Breath		
Asthma/Bronchitis/Emphysema			Heart Attack			Sinus Infections		
Autoimmune Disease			Hernia (Hiatal, Inguinal, Umbilical)			Sleeping Problems/Difficulties		
Blood Clot/Emboli			High Blood Pressure			Stroke/TIA/Brain Injury		
Cancer/Chemotherapy/Radiation			History of Feeding Tube			Thyroid Disease or Goiter		
Chronic Cough			History of Swallowing Problems			Varicose Veins		
Congestive Heart Disease			Lupus			Vision or Hearing Difficulties		
Coronary Artery Disease / Angina			Multiple Sclerosis			Vocal Cord Dysfunction		
Dementia/Alzheimer's Disease			Muscular Dystrophy			Vocal Cord/Throat Viewing		
Diabetes			Numbness or Tingling			Weakness		
Dizziness or Fainting			Osteoporosis			Weight Loss/Energy Loss		
Emotional/Psychological Condition			Pacemaker			Are you Pregnant?		
Endoscopy			Parkinson's Disease			Do you use Tobacco?		
Epilepsy/Seizures			Polio/Post-Polio Syndrome			Frequent alcohol use?		

Surgeries/Injuries	Yes	No		Yes	No		Yes	No
Hip/Knee			Shoulder/Elbow/Wrist/Hand			Cortisone shot/Epidural		
Leg/Ankle/Foot			Joint Replacement			Internal Stimulator (brain/spine)		
Neck/Back			Pins or Metal Implants			Heart		

Other: (List any medical history, procedures, surgeries not specified above) ❑ N/A

_____

Allergies: (List **ANY/ALL** allergies including latex, drug, environmental, food, skin, etc.) ❑ N/A

_____

Communicable Diseases:	Yes	No
Do you have active Tuberculosis (TB) or history of TB (even if on meds)?		
Do you have a history of Methicillin Resistant Staphylococcus Aureus (MRSA)?		
Do you have a history of Vancomycin-Resistant Enterococci (VRE)?		
Do you have a history of Clostridium Difficile (C. diff or C. difficile)?		
Do you have Diarrhea?		

Medication List: (List **ALL** meds you are currently taking, include prescribed, over the counter, vitamins, etc.)

❑ **See attached list** ❑ I am currently **NOT** taking any medication including prescribed, over the counter, vitamins, etc.

PLEASE INFORM US IF YOU BEGIN TAKING ANY NEW MEDICATIONS DURING YOUR COURSE OF THERAPY

Name/Dose	Frequency	Name/Dose	Frequency

Name: _____ DOB: _____

MRN: _____ FIN: _____