Pre-Natal Physiotherapy Health Questionnaire

Please tick if you experience any of the following and give details in the space below:

Pregnancy related:

Placenta Praevia (portion of placenta over cervix)	Y / N	Dizzy/Breathless/Fainting episodes	Y / N	Incompetent Cervix	Y / N
Anaemia / on iron supplements	Y / N	Varicose Veins	Y / N	Pre eclampsia	Y / N
Piles / haemorrhoids / constipation	Y / N	Any unexplained bleeding or during/after exercise	Y / N	Swelling, pain or redness in your calf/groin	Y / N
Any leakage (bladder/bowel) eg. on cough/sneeze/lifting	Y / N	Sudden swelling of hands, face or feet	Y / N	Separation of tummy muscles (diastasis recti)	Y / N
Pelvic girdle pain / symphysis pubis dysfunction (during/after pregnancy)	Y / N	Abdominal pain/cramps	Y / N	Heartburn / Reflux	Y / N
Severe Fatigue	Y / N	Persistent/severe headaches	Y / N	Hyperemesis / Nausea	Y / N

General Health:

Thyroid (under/overactive)	Y / N	Heart Problems	Y / N	Chest pain on activity	Y / N
Reduced bone density (Osteoporosis)	Y / N	History of / current cancer or strong family history of cancer?	Y / N	High/Low blood pressure (including pregnancy related)	Y / N
Ever taken Steroids for 6 months or more	Y / N	Asthma / breathing problems. If so, is it well controlled?	Y / N	Recurrent pins and needles / numbness	Y / N
Epilepsy	Y / N	Any surgery in the last year	Y / N	Joint surgery (including spinal)	Y / N
Diabetes / Gestational Diabetes	Y / N	On regular Medication	Y / N	Eating Disorder	Y / N
Rheumatoid / Osteoarthritis	Y / N	Hernia	Y / N	On blood thinners eg. warfarin	Y / N
Upper back / neck / shoulder pain	Y / N	Any positions you can't exercise in	Y / N	Balance problems (recent changes)	Y / N
Coordination problems (recent changes)	Y / N	Regular pain at night / pain that is worse at night	Y / N	Current smoker / given up in the last 7 years	Y / N
Lower back, buttock or leg pain or sacroiliac joint (SIJ) dysfunction	Y / N	Broken bones (any in the last year / previous with ongoing issues)	Y / N	Carpal tunnel (pins & needles / numbness/tingling/weakness in fingers/wrists)	Y / N
Regular night sweats	Y / N	Other aches and pains	Y / N	Other medical issue	Y / N

Details / Other:

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Name: Signature: