 **Pre-screen Questionnaire**

Date Click here to enter a date.

**Patient Details**

Name Click here to enter text. DOB:Click here to enter a date.

Address Click here to enter text.

Email Click here to enter text. Phone Click here to enter text.

GP Details Click here to enter text.

Are you happy for Maternity Physio to contact your GP, if needed? Yes [ ]  No [ ]

How did you hear about Maternity Physio? Click here to enter text.

**Obstetric History**

**Pregnancy:**

Were there any complications with your most recent pregnancy? Yes[ ]  No[ ]

Please explain further if required Click here to enter text.

Did you suffer from pelvic girdle pain/ SPD/Sacroiliac pain? Yes[ ]  No[ ]

Explain further if neededClick here to enter text.

Did you exercise during the Pregnancy ? Yes[ ]  No[ ]

If yes, what kind of exercise? Click here to enter text.

Have you ever had a miscarriage? Yes[ ]  No[ ]

Click here to enter text.

Are you currently Pregnant? Yes[ ]  No[ ]

**Delivery:**

Date of most recent delivery?Click here to enter a date.

Type of delivery? C-section [ ]  Vaginal Delivery [ ]

Please fill in the relevant section below according to your type of delivery

**C-Section**

Emergency[ ]  Elective [ ]

Were there complications? Yes[ ]  No[ ]

Please explain further here if needed Click here to enter text.

Did your scar heal well? Click here to enter text.

How does it feel now? Click here to enter text.

**Vaginal Delivery**

How long did labour approximately last? Click here to enter text.

Were there any complications or further interventions? Yes[ ]  NO[ ]

Explain further, if neededClick here to enter text.

What was the weight of the baby? If you know Click here to enter text.

Did you have a tear? Yes[ ]  No[ ]

What kind? if you know Click here to enter text.

Did you need stitches? Yes[ ]  No[ ]

If Yes, did they heal well? Click here to enter text.

Please give the date and type of any previous deliveries and whether there were any complications involved>

Click here to enter a date. Click here to enter text.

Click here to enter a date. Click here to enter text.

Click here to enter a date. Click here to enter text.

Click here to enter a date.Click here to enter text.

Click here to enter a date.Click here to enter text.

**Medical History**

Have you had any previous medical conditions such as Diabetes, Cancer, Heart problems, Blood pressure issues, Epilepsy, Rheumatoid Arthritis pre or post pregnancy Yes[ ]  No[ ]

If Yes, please give more info here Click here to enter text.

Have you ever had a major injury or previous surgery in the past? Yes[ ]  No[ ]

If yes, please give more info here rClick here to enter text.

Are you currently taking any medication? Yes[ ]  No[ ]

If yes, which ones? Click here to enter text.

Are you Hypermobile? Yes[ ]  No[ ]  Not sure[ ]

**Current Postnatal Status**

Do you have separated abdominal muscles Yes[ ]  No[ ]  Not sure[ ]

If yes, what is the approximate gap size? Click here to enter text.

Do you have pain in your perineum (undercarriage)? Yes[ ]  No[ ]

Do you have a sensation of pulling/dragging in your perineum at any time? Yes[ ]  No[ ]

If yes, when? Click here to enter text.

Have you ever been diagnosed with a pelvic organ prolapse? Yes[ ]  No[ ]

Do you have pain during intercourse? Yes[ ]  No[ ]  Don’t know yet[ ]

Do you ever experience urinary incontinence? Yes[ ]  No[ ]

If yes, during which situations? Click here to enter text.

Do you ever need to wear pads for urinary incontinence? Yes[ ]  No[ ]

Explain further if you need toClick here to enter text.

Do you have difficulty activating your pelvic floor? Yes[ ]  No[ ]

Do you have any bowel conditions such as IBS or Colitis? Yes[ ]  No[ ]

Explain further if you need toClick here to enter text.

Do you have any bowel incontinence? Yes[ ]  No[ ]

Do you feel you have fully voided after passing a bowel motion? Yes[ ]  No[ ]

Explain further if you need toClick here to enter text.

Are you currently exercising? Yes[ ]  No[ ]

If yes, what kind of exercise? Click here to enter text.

Are there any types of exercise you would like to be able to do ,

but are unable to do at present? Yes[ ]  No[ ]

If yes, explain furtherClick here to enter text.

Have you had your 6week check with the GP yes[ ]  No[ ]

Were there any issues identified Yes[ ]  No[ ] Click here to enter text.

Thanks for taking the time to complete this pre-screen. This will give your postnatal physiotherapist all the information required to carry out an effective and beneficial Mummy MOT and allow more time to focus on the hands-on check. Looking forward to meeting you ☺

**Important Note:**

**As part of your Mummy MOT Check, an internal or vaginal examination may be carried out. This is a useful way of finding about the support of you pelvic organs, strength of the pelvic floor muscles and identify any pelvic floor dysfunction. The examination involves inserting a finger into your vagina to assess the vaginal walls and pelvic floor muscles. This examination is entirely optional and will be discussed and decided between you and your physiotherapist at the time of assessment. It is important that you feel comfortable during your Mummy MOT and you are not under any pressure to give your consent. Also be aware you are entitled to bring a chaperone along for the examination if you wish.**