Pelvic Floor Questionnaire

Name:_____ **Date:** _____
Referring Physician:_____

1) Please describe your main problem:

_____

_____

2) When did it begin?_____ Is it getting **(circle one)**: better / worse / staying the same

3) Please describe activities or things that you cannot do because of this problem:

_____

_____

Medical History:

Do you have or have you had any of the following:

	Yes	No
Diabetes		
Osteoarthritis		
Osteoporosis		
Rheumatoid Arthritis		
Headaches		
Cancer		
Ringing in Ears		
Pacemaker		
Hypoglycemia		
High Blood Pressure		
Heart Disease		
Dizziness/Fainting		
Fevers/Chills		
Weight Changes		
Bowel/Bladder Issues		

If you answered yes to any of the above, please explain:

_____

_____

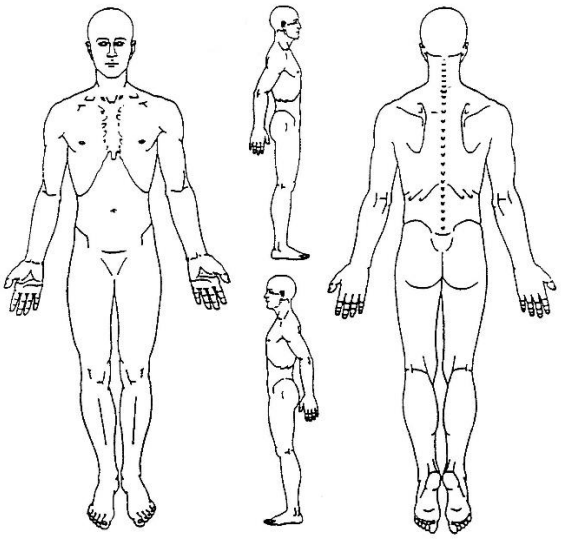
_____

Do you have any allergies? Y / N

Please explain:_____

_____

Please indicate below where your symptoms are located:



KEY: numbness: ====
pins & needles: 0000
stabbing pain: / / / /
burning pain: XXXX

Pain level (0-10, 0=no pain, 10=worst pain):

____ / 10

Surgeries:

Hysterectomy: Y / N Date: _____
C-Section: Y / N Date: _____
Gall Bladder: Y / N Date: _____
Prostatectomy: Y / N Date: _____

Appendectomy: Y / N Date:_____
Hernia repair: Y / N Date:_____
Laparoscopy: Y / N Date:_____
Other surgeries: _____

_____

_____

Are you currently taking any medication/supplements (prescription or over-the-counter)? **Yes**____ **No**____
If yes, please list medications:

Medication name: **Dosage/ frequency** **Route (i.e.: oral, cream)**

_____
_____
_____
_____
_____
_____
_____

Bladder Questionnaire:

	Never	Sometimes	Often	N/A
1. Do you leak urine when you cough, sneeze, laugh, or when lifting?				
2. Do you ever have such an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?				
3. If "yes" to question #2, do you ever leak before you reach the toilet?				
4. Do you have an urge to urinate when you hear running water?				
5. Do you have an urge to urinate when your hands are in water?				
6. Do you ever leak during or after sexual intercourse?				
7. Have you had bladder, urinary or kidney infections?				
8. Are you troubled by pain or discomfort when you urinate or BM?				
9. Have you had blood in your urine?				
10. Do you find it hard to begin to urinate?				
11. Do you have a slow urine stream?				
12. Do you strain to pass your urine or BM?				
13. After you urinate, do you have dribbling or a feeling that your bladder is still full?				
14. After BM, do you feel an incomplete emptying?				
15. Do you have burning when you void?				

Please try to give actual numbers for the following questions:

How many times during the day do you urinate? _____
How many times do you void during the night after you go to bed? _____
How often do you leak? _____
Do you wear protection? (**circle one**) No Protection Pantishields Mini pad
Maxi Pad Diaper/Serenity
How many pads do you use in a day? _____
Leakage equals (**circle one**): Small (less than one-half cup) Large (more than one-half cup)
How much warning time do you have to get to the toilet? Seconds or Minutes _____
Fluid Intake: (Includes water and other beverages): 8 oz glasses per day (**circle one below**):
9+ *6-8* *3-5* *1-2*
Caffeinated drinks per day (**circle one**): *9 +* *6-8* *3-5* *1-2*

Additional Pelvic Health Questions:

Are you sexually active? Yes_____ No_____
Do you have a history of, or present, sexually transmitted disease? Yes_____ No_____
If yes, please explain:_____

Do you experience pain or other problems with sexual activity? Yes _____ No _____
If yes, please describe:

_____

_____

Have you ever been taught how to do pelvic floor or Kegel exercises? Yes_____ No_____
If yes, when?_____ By whom?_____ How often do you do them?_____

Frequency of bowel movements? (**circle one:)**
2+ times per day 1 time per day Every other day Once every 4-6 days Weekly

Any comments or concerns not addressed in this questionnaire?

_____

_____

_____

<u>Questions for female patients only</u>:

Gynecological History: Please provide information on any of the following that apply to you:

Have you been diagnosed with:

	Yes	No
Pelvic Organ Prolapse		
Endometriosis		
Cysts		
Urinary Tract Infections		
Pelvic Inflammation Disease		
Fibroids		
Pelvic pain		

Have your menstrual periods stopped? Yes / No Date of last period: _____
Do/did you have pain with your menstrual periods? Yes / No
Are you on hormone replacement therapy? Yes / No
If yes, which one(s):

_____

_____

Other issues not listed?

_____

Are you pregnant? Yes_____ No_____ Attempting to get pregnant? Yes____No_____