Pelvic Floor Questionnaire

Patient Name: _____ Physician: _____

Please describe your main problem:

_____

_____

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

Please describe activities or things that you cannot do because of your problem:

_____

_____

Please list all pelvic and abdominal surgeries with dates of operation:

_____

_____

_____

_____

Date of last pelvic examination: _____ Date of last urinalysis: _____

Special test(s) performed? _____ Type: _____ Date: _____

1. OCCURANCE OF INCONTINENCE OR LEAKAGE (circle all that apply)
Never Less than 1 month More than 1 month Less than 1 week More than 1 week Almost every day #____Leaks per day

2. PROTECTION USED (circle all that apply)
No protection Pantishields Mini pad Maxi pad Bladder control pad type_____ Diaper

3. SEVERITY (circle all that apply)
No leakage Few drops Wet underwear Wet outerwear

4. POSITION OR ACTIVITY WITH LEAKAGE (circle all that apply)
Lying down Sitting Standing Changing positions (sit to stand) Sexual activity Strong urge

5. HOW LONG CAN YOU DELAY THE NEED TO URINATE (circle all that apply)
Indefinitely 1+ hours ½ hour 15 minutes Less than 10 minutes 1-2 minutes Not at all

6. ACTIVITY THAT CAUSES URINE LOSS (circle all that apply)
Vigorous activity Moderate activity Light activity No activity Other Type_____

7. PROLAPSE - *FALLING OUT FEELING* (circle all that apply)
Never Occasionally/with menses Pressure end of the day Pressure w/straining Pressure w/standing Perineal pressure all day

8. FREQUENCY OF DAYTIME URINATION (circle all that apply)
0 times per day 1-4 5-8 9-12 13+

9. FREQUENCY OF NIGHTIME URINATION (circle all that apply)
0 times per night 1 2 3 4+

10. FLUID INTAKE (circle all that apply)
Includes water and beverage ***9+ 8oz glasses per day*** ***6 - 8 8oz glasses per day*** ***3 - 5 8oz glasses per day***
1 – 2 8oz glasses per day ***How many caffeinated glasses?_____***

11. FREQUENCY OF BOWL MOVEMENTS (circle all that apply)
2 times per day ***1 time per day*** ***Every other day*** ***Once every 4 – 7 days*** ***Weekly***

12. AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW? (circle all that apply)
Can stop completely ***Can maintain a deflection of the stream***
Can partially deflect the urine stream ***Unable to deflect or slow the stream***

13. DO YOU HAVE TROUBLE INITIATING A URINE STREAM (circle all that apply)
Never ***More than 1 month*** ***Less than 1 month*** ***Almost every day***

14. ATTITUDE TOWARDS PROBLEM (circle all that apply)
No problem ***Minor inconvenience*** ***Slight problem*** ***Moderate problem*** ***Major problem***

15. CONFIDENCE IN CONTROLLING YOUR PROBLEM (circle all that apply)
Complete confidence ***Moderate confidence*** ***Little confidence*** ***No confidence***

16. ARE YOU SEXUALLY ACTIVE? **YES** **NO** (circle one)
ARE YOU PREGNANT OR ATTEMPTING PREGNANCY? **YES** **NO** (circle one)
NUMBER OF PREGNANCIES? _____
COMPLICATIONS? _____
_____
_____

17. ARE YOU SEXUALLY ACTIVE? **YES** **NO** (circle one)
HISTORY OF OR PRESENT SEXUALLY TRANSMITTED DISEASES? **YES** **NO** (circle one)
TYPE :_____

18. DO YOU HAVE PAIN OR PROBLEMS WITH SEXUAL ACTIVITY OR URINATION? **YES** **NO** (circle one)
DESCRIBE: _____

19. HAVE YOU BEEN TAUGHT OR PERSCRIBED TO DO PELVIC FLOOR/KEGEL EXCERXISES? **YES** **NO**
(circle one)
WHEN? _____ BY WHOM? _____

20. HOW OFTEN DO YOU DO PELVIC FLOOR EXCERCISES? _____

ADDITONAL COMMENTS OR CONCERNS?
_____
_____
_____
_____
_____
_____
_____
_____
_____