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Pelvic Floor Questionnaire

Name _____ Physician _____ Date _____

Please describe your main problem: _____

When did it begin? _____ Is it getting: better, worse, same ? (circle one)

Describe activities or things that you cannot do because of your condition. _____

Surgical History (Please date all that apply)

_____ back/neck surgery	_____ appendectomy
_____ bladder repair	_____ hernia
_____ hysterectomy (vaginal/abdominal)	_____ ovaries removed
_____ kidney surgery	Do you have a pacemaker? ____ Yes ____ No
_____ gall bladder surgery	Do you have an IUD? ____ Yes ____ No
	If yes, ____ Copper? ____ Mirena?

Gynecological History

_____ # of pregnancies	_____ # of miscarriages
_____ # of vaginal deliveries	_____ # of abortions
_____ # of C-sections	
_____ # of episiotomies	
_____ Any delivery problems? If yes, please describe _____	
Any history of urinary tract infections? _____ If yes, how often? _____	
Menopausal state _____	Date of last pelvic exam _____
Date of last urinalysis _____	Other special tests done? _____
Any history of sexual abuse? _____	
Do you take medication for urinary leakage (incontinence)? ____ Yes ____ No	
If Yes, what medications _____	

Incontinence/Leakage (please circle)

<u>Frequency of Leakage</u>	<u>Protection Worn</u>	<u>Severity of Leakage</u>
Never	None	None
Less than 1 month	pantishields	Few drops
More than 1 month	mini pads	Wet underwear
Less than 1 week	maxi pads	Wet outerwear
More than 1/week	serenity/poise/depends	
# ____ leaks / day	# ____ pads/day	

The Causes of Urine loss

Vigorous activity
Moderate activity
Light activity
No activity
Type _____

Position/activity with leakage

Lying down Exercise
Sitting Sexual activity
Standing on way to bathroom
Coughing running water
Sneezing changing position
Laughing strong urge
Running removing clothes
Lifting "key in the lock"
Other _____

Can you delay the urge?

Indefinitely
1+ hours
½ hour
15 minutes
less than 10 minutes
1-2 minutes
not at all

Prolapse (falling out feeling)

Never
Occasionally/with menses
Pressure at end of the day
Pressure with standing
Pressure with straining
Pressure all day

Frequency of bowel movements

2 times per day
1 time per day
every other day
once every 4-7 days
problems with constipation
other bowel problems? _____

Do you have trouble controlling your bowels? ___ Yes ___ No

Do you have trouble controlling gas leakage? ___ Yes ___ No

If yes, do you lose stool/bowels by:

Continuous oozing
In small amounts
In moderate amounts
In sudden amounts
Other _____

Do you lose stool with any of the following:

Coughing/sneezing changing position
laughing running
Lifting Other _____
Exercise _____
On way to bathroom

Do you wear a pad? If yes, how many per day? _____

Frequency of urination (daytime)

0 times per day
1-4
5-8
9-12
13 +
Every ___ hours

Frequency of urination (nighttime)

0 times per night
1
2
3
4+
Every ___ hours

Fluid Intake (including water and other beverages)

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 are caffeinated? _____ alcohol? _____

After starting to urinate, can you completely stop the flow?

- Can stop completely
- Can maintain a deflection of the stream
- Can partially deflect the stream
- Unable to deflect or slow the stream

Do you dribble urine?

- when urinating
- after emptying bladder
- never

Do you have trouble initiating a stream? _____

- Never
- More than 1 time/month
- More than 1 time/week
- Almost every day

Attitude toward your problem

- No problem
- Minor inconvenience
- Slight problem
- Moderate problem
- Major problem

Confidence in ability to control leakage

- Complete confidence
- Moderate confidence
- Little confidence
- No confidence

Are you sexually active? ____yes ____ no

Are you pregnant or attempting pregnancy? ____yes ____ no

Presence of or History of sexually transmitted diseases? Type _____

Do you have pain or problems with sexual activity or urination? 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 pelvic floor exercises? _____

What is your goal for treatment of your pelvic floor training (incontinence problem)? _____

Are you considering surgery as an option for your urinary/bowel problem? ____yes ____ no

Any other comments or concerns not addressed? _____

Thank You.