Sage Health Care

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Pelvic Floor Questionnaire

Name_____ **Date of Birth** _____

Primary Care Physician_____ **Who Referred you to Sage?**_____

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

Gynecological History

_____ # of pregnancies
_____ # of vaginal deliveries
_____ # of C-sections
_____ # of episiotomies
_____ # of miscarriages
_____ # of abortions
_____ 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 _____

Name_____ DOB_____

Incontinence/Leakage (please circle)

Frequency of Leakage	Protection Worn	Severity of Leakage
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
laughing
Lifting
Exercise
On way to bathroom
changing position
running
Other_____
_____

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

Name_____ DOB_____

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.