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| **PELVIC FLOOR QUESTIONNAIRE** |

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hours worked per week\_\_\_\_\_\_\_\_\_\_**

**What are your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did symptoms start? (Onset Date) \_\_\_\_\_\_\_\_\_\_\_Surgery Date \_\_\_\_\_\_\_\_\_\_\_Where did you have surgery? \_\_\_\_\_\_\_\_\_\_\_\_**

**Cause of symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Since onset, your symptoms are:**  **Worse**  **Same**  **Better Prior to this onset, were you symptom free?  Yes  No**

**What increases your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What decreases your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Worst pain**

**Please rate your current pain (circle): (No pain) (Moderate) imaginable)**

**0 1 2 3 4 5 6 7 8 9 10**

**Daily Activities: Home/Leisure Limitations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Self-Care Limitations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you exercise? \_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any allergies?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

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| **Ob/Gyn History (Females Only)** | | | |
| Yes No | Births: vaginal # \_\_\_\_ c-section #\_\_\_\_ | Yes No | Menopause - When? |
| Yes No | Difficult childbirth | Yes No | Pelvic/genital pain |
| Yes No | Vaginal dryness | Yes No | Hysterectomy |
| Yes No | Pregnant or attempting pregnancy | Yes No | IUD in place |
| Yes No | Prolapse/Rectocele/Cystocele | Yes No | Endometriosis |
| Yes No | Painful Menstruation |  |  |
| Comments: | | | |
| **Males Only** | | | |
| Yes No | Prostate disorders | Yes No | Erectile Dysfunction |
| Yes No | Shy bladder | Yes No | Painful Ejaculation |
| Yes No | Pelvic/genital pain | Yes No | Hernia – Where? |
| Comments: | | | |

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| **Bladder Symptoms** | | | |
| Yes No | Trouble initiating urine stream | Yes No | Dribbling after urination |
| Yes No | Urine intermittent/slow stream | Yes No | Constant urine leakage |
| Yes No | Strain or push to empty bladder | Yes No | Trouble feeling bladder urge/fullness |
| Yes No | Need to urinate with little warning | Yes No | Recurrent bladder infections |
| Yes No | Trouble emptying bladder completely | Yes No | Painful urination |
| Yes No | Blood in urine | Yes No | Volume passed \_\_small \_\_med \_\_large |
| Comments: | | | |
| **Urinary Habits** | | | |
| **Frequency of urination:** Every \_\_\_\_minutes; Every \_\_\_\_ hours; \_\_\_\_times per day; \_\_\_\_times per night | | | |
| **On average, how much do you leak?** None Just a few drops Wet underwear Wet the floor Soaked pads | | | |
| **Can you delay before you go to toilet?** \_\_\_\_\_ minutes (# of minutes) \_\_\_\_\_hours (# of hours) Not at all | | | |
| **Bladder leakage: # of episodes:** None without awareness with exertion/cough with urge  \_\_\_\_times/day; \_\_\_\_times/week; \_\_\_\_times/month | | | |
| **What form of protection do you wear?** None  Minimal protection (toilet paper/pantishield)  Moderate protection (absorbent product/maxipad)  Maximum protection (specialty product/diaper) | | | |
| **On average, how many pad changes are required during daytime?** \_\_\_\_\_(#of pads) **at night?**\_\_\_\_(#of pads)  Are they damp\_\_\_\_ wet \_\_\_\_\_ soaked\_\_\_\_\_ | | | |
| **Average fluid intake**(1glass = 8 oz) \_\_\_\_# glasses/day  Of this total how many glasses are: Caffeinated? \_\_\_\_# glasses/day Fruit drinks? \_\_\_\_# glasses/day  Alcoholic? \_\_\_\_# glasses/day Water? \_\_\_\_# glasses/day | | | |
| Comments: | | | |
| **Bowel History** | | | |
| Yes No | Blood in bowel movement (BM) | Yes No | Trouble emptying bowel completely |
| Yes No | Painful BM | Yes No | Need to support/splint to complete BM |
| Yes No | Trouble feeling bowel urge | Yes No | Constipation/straining \_\_\_\_% of time |
| Yes No | Trouble holding back gas | Yes No | Current laxative use |
| Yes No | Trouble starting BM | Yes No | Fecal leakage \_\_\_times/day \_\_\_times/week |
| Comments: | | | |
| **Bowel Symptoms** | | | |
| **Frequency of bowel movements:** \_\_\_\_times/day; \_\_\_\_times/week | | | |
| **When you have the urge to have a bowel movement, how long can you delay?** Minutes Hours Not at all | | | |
| **Bowel movements are typically:**  Watery  Loose  Formed  Pellets  Thin  Hard | | | |
| If constipation is present, describe management techniques: | | | |
| Comments: | | | |

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| **Rate a feeling of organ ”falling out”/prolapse or pelvic heaviness/pressure** | |
| None present | With standing for \_\_\_\_minutes or \_\_\_\_hours |
| With exertion or straining | With menses |
| Pressure at end of the day | Pressure all day |
| Comments: | |

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| **Sexual History** | | | | |
| Yes No | Sexually active | | Yes No | Pain with initial entry |
| Yes No | Pain with penetration | | Yes No | Pain with deep thrust |
| **If Yes,** | Yes No | with tampon (females) | Yes No | Bleeding with or following intercourse |
|  | Yes No | with speculum(females) | Yes No | History of sexual abuse |
|  | Yes No | Pain w/erection(males) | Comments: | |
|  | Yes No | Pain w/ejaculation (males) |

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| **Activities that cause or aggravate any of your bladder/bowel symptoms or pain (check all that apply)** | |
| Sitting greater than \_\_\_\_minutes | Laughing/yelling |
| Walking greater than \_\_\_\_minutes | Lifting/bending |
| Standing greater than \_\_\_\_minutes | Cold weather |
| Changing positions (sit to stand) | Triggers (key in the door/running the water) |
| Light activity (light housework) | Nervousness/anxiety |
| Vigorous activity/exercise (run, weight lift, jump) | Sleeping |
| Sexual activity | No activity affects the problem |
| Cough/sneeze/straining |  |
| Comments: | |

Please list your goals. (What do you want this treatment to do for you?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your current medications:

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| Patient History Form | | | | | | |
| Patient Name | | | | Date | | |
| **Medical History** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| High Blood Pressure | ⃝ | ⃝ | Fracture |  | ⃝ | ⃝ |
| Heart Attack | ⃝ | ⃝ | Rheumatoid arthritis | | ⃝ | ⃝ |
| Congestive heart failure | ⃝ | ⃝ | Osteoarthritis |  | ⃝ | ⃝ |
| Pacemaker | ⃝ | ⃝ | Gout |  | ⃝ | ⃝ |
| Raynauds | ⃝ | ⃝ | Neuropathy |  | ⃝ | ⃝ |
| Asthma | ⃝ | ⃝ | Parkinsons |  | ⃝ | ⃝ |
| COPD | ⃝ | ⃝ | Alzeheimers |  | ⃝ | ⃝ |
| Stroke | ⃝ | ⃝ | MS |  | ⃝ | ⃝ |
| Vertigo/Dizziness | ⃝ | ⃝ | Fibromyalgia |  | ⃝ | ⃝ |
| Seizures | ⃝ | ⃝ | HIV |  | ⃝ | ⃝ |
| Migraines | ⃝ | ⃝ | Osteoperosis |  | ⃝ | ⃝ |
| Thyroid Disease | ⃝ | ⃝ | Liver Disease |  | ⃝ | ⃝ |
| Diabetes | ⃝ | ⃝ | Hepatitis |  | ⃝ | ⃝ |
| Kidney Disease | ⃝ | ⃝ | Reflux |  | ⃝ | ⃝ |
| Herpes | ⃝ | ⃝ | Leukemia |  | ⃝ | ⃝ |
| Shingles | ⃝ | ⃝ | Bleeding Disorder | | ⃝ | ⃝ |
| IBS | ⃝ | ⃝ | Constipation |  | ⃝ | ⃝ |
| Psoriasis | ⃝ | ⃝ | Diarrhea |  | ⃝ | ⃝ |
| Eczema | ⃝ | ⃝ | Interstitial Cystitis | | ⃝ | ⃝ |
| Open sores | ⃝ | ⃝ | Prostate problems | | ⃝ | ⃝ |
| Rash | ⃝ | ⃝ |  |  |  |  |
|  |  |  |  |  |  |  |
| Cancer (specify right ) | ⃝ | ⃝ |  | | | |
| Auto-Immune Disease | | | | | | |
| Have you had any serious illness not listed above? No ⃝ Yes | | | | | | |
| Do you bruise easily? | Yes ⃝ | No ⃝ |  |  |  |  |
| Surgeries | | | | | | |
|  | | | | | | |
| Noteable family medical history? | | | | | | |
|  |  |  | Turn Over |  |  |  |

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| **Social History** |  |  |  |
|  |  |  |  |
| Alcohol use | ⃝ | ⃝ | (type and frequency) |
| Tobacco use | ⃝ | ⃝ | (type and ammount per day) |
| Have you experienced: |  |  |  |
| Anxiety | ⃝ | ⃝ |  |
| Depression | ⃝ | ⃝ |  |
| Bipolar | ⃝ | ⃝ |  |
| Thoughts of wanting to harm  yourself or others? | ⃝ | ⃝ |  |
|  |  |  |  |
| Do you live alone? | ⃝ | ⃝ |  |
| Do you have good emotional support? | ⃝ | ⃝ |  |
| Do you use a seat belt? | Always ⃝ Sometimes ⃝ Never ⃝ | | |
| Diet? (Please Rate) | Good ⃝ Fair ⃝ Poor ⃝ | | |
| Any other current life event that may impact therapy? (moving, baby, family death, job change, etc) | | | |
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