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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/dayOf 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?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 harmyourself 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)  |
|  |