



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? _____

Please rate your current pain (circle): (No pain) 0 1 2 3 (Moderate) 4 5 6 7 8 9 10 (Worst pain imaginable)

Daily Activities: Home/Leisure Limitations _____

Self-Care Limitations _____

Do you exercise? _____ How often? _____ Type _____

Do you have any allergies? _____

Medical History:

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

Bladder Symptoms			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble initiating urine stream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dribbling after urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Urine intermittent/slow stream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constant urine leakage
<input type="checkbox"/> Yes <input type="checkbox"/> No	Strain or push to empty bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble feeling bladder urge/fullness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Need to urinate with little warning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent bladder infections
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble emptying bladder completely	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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 (1 glass = 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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in bowel movement (BM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble emptying bowel completely
<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful BM	<input type="checkbox"/> Yes <input type="checkbox"/> No	Need to support/splint to complete BM
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble feeling bowel urge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation/straining ___ % of time
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble holding back gas	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current laxative use
<input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble starting BM	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Rate a feeling of organ "falling out"/prolapse or pelvic heaviness/pressure

<input type="checkbox"/> None present	<input type="checkbox"/> With standing for ___ minutes or ___ hours
<input type="checkbox"/> With exertion or straining	<input type="checkbox"/> With menses
<input type="checkbox"/> Pressure at end of the day	<input type="checkbox"/> Pressure all day

Comments:

Sexual History			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with initial entry
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with penetration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with deep thrust
If Yes,	<input type="checkbox"/> Yes <input type="checkbox"/> No	with tampon (females)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	with speculum(females)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain w/erection(males)	Comments:
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain w/ejaculation (males)	

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

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

Please list your current medications: _____

Patient History Form

Patient Name _____ Date _____

Medical History

	Current	Past		Current	Past
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Fracture	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>
Congestive heart failure	<input type="radio"/>	<input type="radio"/>	Osteoarthritis	<input type="radio"/>	<input type="radio"/>
Pacemaker	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>
Raynauds	<input type="radio"/>	<input type="radio"/>	Neuropathy	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Parkinsons	<input type="radio"/>	<input type="radio"/>
COPD	<input type="radio"/>	<input type="radio"/>	Alzeheimers	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	MS	<input type="radio"/>	<input type="radio"/>
Vertigo/Dizziness	<input type="radio"/>	<input type="radio"/>	Fibromyalgia	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	Osteoperosis	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	Reflux	<input type="radio"/>	<input type="radio"/>
Herpes	<input type="radio"/>	<input type="radio"/>	Leukemia	<input type="radio"/>	<input type="radio"/>
Shingles	<input type="radio"/>	<input type="radio"/>	Bleeding Disorder	<input type="radio"/>	<input type="radio"/>
IBS	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>
Psoriasis	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>	Interstitial Cystitis	<input type="radio"/>	<input type="radio"/>
Open sores	<input type="radio"/>	<input type="radio"/>	Prostate problems	<input type="radio"/>	<input type="radio"/>
Rash	<input type="radio"/>	<input type="radio"/>			

Cancer (specify right) Current Past _____

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

Social History

	Current	Past	
Alcohol use	<input type="radio"/>	<input type="radio"/>	(type and frequency) _____
Tobacco use	<input type="radio"/>	<input type="radio"/>	(type and ammount per day) _____
Have you experienced:			
Anxiety	<input type="radio"/>	<input type="radio"/>	
Depression	<input type="radio"/>	<input type="radio"/>	
Bipolar	<input type="radio"/>	<input type="radio"/>	
Thoughts of wanting to harm yourself or others?	<input type="radio"/>	<input type="radio"/>	
	Yes	No	
Do you live alone?	<input type="radio"/>	<input type="radio"/>	
Do you have good emotional support?	<input type="radio"/>	<input type="radio"/>	
Do you use a seat belt?	Always <input type="radio"/>	Sometimes <input type="radio"/>	Never <input type="radio"/>
Diet? (Please Rate)	Good <input type="radio"/>	Fair <input type="radio"/>	Poor <input type="radio"/>
Any other current life event that may impact therapy? (moving, baby, family death, job change, etc)	_____		
