PELVIC FLOOR QUESTIONNAIRE

Legal Name_____ **Preferred Name** _____ **Age** _____

Pronouns ☐ **She/her** ☐ **He/him** ☐ **They/them** ☐ **Other** _____ **Gender Identity**_____

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) (Moderate) (Worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

What activities do you feel limited in because of your symptoms? _____

_____

Do you exercise? _____ **How often?** _____ **Type** _____

Medical History:

Please fill out the section(s) below that are most relevant to your anatomy:			
☐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:			
☐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:			

Bladder Symptoms			
☐Yes ☐No	Trouble initiating urine stream	☐Yes ☐No	Trouble feeling bladder urge/fullness
☐Yes ☐No	Urine intermittent/slow stream	☐Yes ☐No	Recurrent bladder infections
☐Yes ☐No	Strain or push to empty bladder	☐Yes ☐No	Painful urination
☐Yes ☐No	Trouble emptying bladder completely	☐Yes ☐No	Blood in urine
☐Yes ☐No	Dribbling after urination	☐Yes ☐No	Volume passed __small __med __large
Comments:			

Bladder Symptoms

Frequency of urination: During the day every _____(# of minutes or hours) ____times per night

Can you delay before you go to toilet? _____ minutes (# of minutes or hours) ☐Not at all

What tends to trigger a strong sense of urinary urgency? ☐Arriving home ☐Walking to the bathroom ☐Running water ☐Preparing to leave home ☐Preparing for bed ☐Other: _____

On average, how much do you leak? ☐None ☐Just a few drops ☐Wet underwear ☐Wet the floor

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/panty shield)
☐Moderate protection (absorbent product/maxi pad)
☐Maximum protection (specialty product/diaper)

On average, how many pad changes are required? Day:_____(#of pads) N**ight:**_____(#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 ☐Juice/soda? ____# glasses/day
☐Alcoholic? ____# glasses/day ☐Water? ____# glasses/day

Comments:

Bowel Symptoms

☐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:

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:

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	☐Yes ☐No	Bleeding with or following intercourse	
	☐Yes ☐No	with speculum	☐Yes ☐No	History of sexual abuse	
	☐Yes ☐No	Pain w/erection	Comments:		
	☐Yes ☐No	Pain w/ejaculation			

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	☐Cough/sneeze/straining
☐Standing greater than ____minutes	☐Lifting/bending
☐Changing positions (sit to stand)	☐Cold weather
☐Light activity (light housework)	☐Nervousness/anxiety
☐Vigorous activity/exercise (run, weight lift, jump)	☐Sleeping
☐Sexual activity	☐No activity affects the problem
Comments:	

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

_____

_____

Please list your current medications or attach a complete list: _____

_____

_____

Do you have any allergies? _____

What previous treatments or tests have you had: _____

_____

_____

Patient History Form

Patient Name _____ Date _____

Medical History

High blood pressure	◯	Fracture	◯
Heart attack	◯	Rheumatoid arthritis	◯
Congestive heart failure	◯	Osteoarthritis	◯
Pacemaker	◯	Gout	◯
Raynaud's	◯	Neuropathy	◯
Asthma	◯	Parkinson's	◯
COPD	◯	Alzheimer's	◯
Stroke	◯	MS	◯
Vertigo/dizziness	◯	Fibromyalgia	◯
Seizures	◯	HIV	◯
Migraines	◯	Osteoporosis	◯
Thyroid condition	◯	Liver disease	◯
Diabetes	◯	Hepatitis	◯
Kidney disease	◯	Reflux	◯
Herpes	◯	Sleep apnea	◯
Shingles	◯	Bleeding disorder	◯
IBS	◯	Constipation	◯
Psoriasis	◯	Diarrhea	◯
Eczema	◯	Interstitial cystitis	◯
Open sores	◯	Prostate problems	◯
Rash	◯		

Cancer (specify right) ◯ _____

Auto-Immune Disease _____

Do you have any other condition not listed above? No ◯ Yes _____

Do you bruise easily? Yes ◯ No ◯

Surgeries_____

_____

Notable family medical history?_____

Social History

Alcohol use ◯ (type and frequency)_____

Tobacco use ◯ (type and amount per day) _____

Have you experienced:	Yes	No	
Anxiety	◯	◯	
Depression	◯	◯	
Other Mental Illness	◯	◯	Option to list: _____
Thoughts of wanting to harm yourself or others?	◯	◯	

	Yes	No
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)_____

_____