PELVIC FLOOR GENERAL QUESTIONNAIRE

Name _____ **MR#**_____ **Age** _____ **Date** _____

1. Describe the current problem that brought you here?

2. When did your problem first begin? ____months ago or ____years ago.

3. Was your first episode of the problem related to a specific incident? YES / NO

Please describe and specify date _____

Since that time is it: □staying the same □getting worse □getting better

Why or how?

What relieves your symptoms?

4. Activities/events that cause or aggravate your symptoms. *(Check all that apply)*

- □ Sitting greater than _____ minutes
- □ Walking greater than _____ minutes
- □ Standing greater than _____ minutes
- □ Changing positions (i.e. - sit to stand)
- □ Light activity (light housework)
- □ Vigorous activity/exercise (run/weight lift/jump)
- □ With nervousness/anxiety
- □ With cough/sneeze/straining
- □ With laughing/yelling
- □ With lifting/bending
- □ With cold weather
- □ With triggers -running water/key in door
- □ Other. Please list:

5. If pain is present, rate pain on a 0-10 scale. 10 being the worst. _____. Describe the nature of the pain and location (i.e. constant burning, intermittent ache):

6. Date of last medical exam for this issue:

7. Tests performed for current complaint:

8. Describe previous treatment/exercises for current symptoms:

9. Check all that apply: □ currently pregnant □ active vaginal infection □ surgery in past 2 months

10. What are your treatment goals/concerns?

Ob/Gyn History (FEMALES Only)

Number of pregnancies ____
Vaginal deliveries #_____C-Section #____

Y / N Episiotomy #____
Y / N Menopause When?
Y / N Hormone Therapy. If so, explain:

Y / N Pelvic pain
Y/ N Painful vaginal penetration
Y / N Painful periods
Y / N Vaginal dryness
Y / N Prolapse or organ falling out
Y/ N Surgery for your female organs

MALES Only

Y / N Prostate disorders
Y / N Shy bladder
Y / N Pelvic pain
Y / N Other. Describe:

Y / N Erectile dysfunction
Y / N Painful ejaculation
Y / N Surgery for your male organs

Name _____ **MR#**_____ **Age** _____ **Date** _____

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems:

Y / N Trouble initiating urine stream
Y / N Urinary intermittent /slow stream
Y / N Trouble emptying bladder
Y / N Difficulty stopping the urine stream
Y / N Straining or pushing to empty bladder
Y / N Dribbling after urination
Y / N Constant urine leakage
Y / N Other. Describe:

Y / N Painful urination
Y / N Trouble feeling bladder urge/fullness
Y / N Current laxative use
Y / N Trouble feeling bowel/urge/fullness
Y / N Constipation/straining
Y / N Trouble holding back gas/feces
Y / N Recurrent bladder infections

1. **Frequency of urination**:

   Awake Hours: times/day_____ Sleep Hours: times/night ____

   When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   minutes ___ hours ___ not at all ____

2. **Frequency of bowel movements:**

   times/day ____ or times/week ____

   When you have a bowel movement urge, how long can you delay before you have to go to the

   toilet? _____ minutes, ___ hours, ___ not at all

3. If constipation is present, describe management techniques:

4. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
   - ___ None present
   - ___ Times per month (specify if related to activity or your period)
   - ___ With standing for ___ minutes or ___hours
   - ___ With exertion or straining
   - ___ Other

5. Bladder leakage - number of episodes**.**
   - ___ No leakage
   - ___ Times per day
   - ___ Times per week
   - ___ Times per month
   - ___ Only with physical exertion/cough

   Bowel leakage - number of episodes
   - ___ No leakage
   - ___ Times per day
   - ___ Times per week
   - ___ Times per month
   - ___ Only with exertion/strong urge

6. On average, how much urine do you leak?
   - __ No leakage
   - __ Just a few drops
   - __ Wets underwear
   - __ Wets outerwear
   - __ Wets the floor

   How much stool do you lose?
   - __ No leakage
   - __ Stool staining
   - __ Small amount in underwear
   - __ Complete emptying

7. What form of protection do you wear? (Please complete <u>only one</u>)
   - ___ None
   - ___ Minimal protection (Tissue paper/paper towel/panty shields)
   - ___ Moderate protection (absorbent product, maxi pad)
   - ___ Maximum protection (Specialty product/diaper)

8. How many pad changes required in 24 hour period?

Name _____ **MR#**_____ **Age** _____ **Date** _____

Sexual Activity:

Are you currently sexually active? YES / NO

Do you have any pain, irritation, burning, and/or muscle spasm w/ penetration?
Where:

Dyspareunia is a medical term for painful penetration graded on three levels:

Level 1: painful but with same frequency

Level 2: painful and limits frequency

Level 3: painful and prevents penetration

How long after intercourse do you have pain?

What lubrication do you use?

What positions are comfortable?

What positions are uncomfortable?

Diet and Fluid Habits:

Average **WATER** intake (*one glass is 8 oz. or one cup*) _____ glasses per day.

Average glasses: **coffee/tea**___; **soda** ____ **juices**____ **artificially sweetened** ___

When do you drink? Number of drinks: AM____ Afternoon_____ PM_____

Patient Specific Functional Scale:

How has your lifestyle/quality of life been altered/changed because of this problem?(*Social activities, Diet /Fluid intake, Physical activity, Work, Other*)

Please identify up to three important activities that you are unable to do, are having difficulty with, or poor quality of life as a result of your problem.

	Unable/difficult ←										Completely Able →
1._____	0	1	2	3	4	5	6	7	8	9	10
2._____	0	1	2	3	4	5	6	7	8	9	10
3._____	0	1	2	3	4	5	6	7	8	9	10

Patient Signature _____ Date _____

Therapist Signature _____ Date _____