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)** **(Moderate)** **(Worst pain 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** _____

Medical History:

MEDICATIONS & ALLERGIES

Please list (or provide us with a separate list) of any medications you are currently taking and any allergies you have

MEDICATION:			
☐ Refer to attached medication list provided by patient			
ALLERGIES:			

MEDICAL DIAGNOSES AND CONDITIONS

Please check those *current or past* items that apply to you

General Health	☐ Fatigue ☐ Weight change ☐ Fever ☐ Chills ☐ Night sweats ☐ Recent illness ☐ Excess Thirst ☐ Cancer ☐ Diabetes ☐ Thyroid problem ☐ Bleeding ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Back Pain
Lungs/Breathing	☐ Coughing ☐ Asthma ☐ Allergy ☐ Emphysema ☐ COPD ☐ Smoker (if yes, how many packs per day?_____)
Gastrointestinal/ Stomach/Urinary	☐ Nausea ☐ Vomiting ☐ Kidney disease ☐ Hiatal hernia ☐ Reflux ☐ Heartburn ☐ Trouble swallowing ☐ Irritable bowel syndrome ☐ Constipation ☐ Diarrhea ☐ Interstitial cystitis
Genitourinary	☐ Currently pregnant (If yes, how many weeks?)_____ ☐ Incontinence (circle) Bladder/Bowel ☐ Prostate problems ☐ Infections ☐ Frequent or painful urination
Musculoskeletal	☐ Back/neck/joint problems ☐ Osteoporosis
Skin	☐ Rash ☐ Bruise easily ☐ Open sores ☐ Recent tattoos ☐ Psoriasis ☐ Eczema
Neurological	☐ Stroke ☐ Parkinson's ☐ MS ☐ Fibromyalgia

Please list any other Conditions not noted above:

What previous treatments or tests have you had?

☐ X-Rays ☐ CT Scan ☐ MRI ☐ Injections ☐ EMG ☐ Other _____

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:

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 (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)		

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 any surgeries you have had and when:

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:

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

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: