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Pelvic Floor Questionnaire

Name_____ Physician_____ Date_____

General Information: (everyone please complete this section)
Please describe your main problem: _____
_____
_____
When did this problem begin? _____
Is it getting better, worse, or staying the same? _____
Please describe activities or things that you cannot do because of your problem: _____
_____
_____
Occupation:_____
What do you do in your free time? (Leisure activities, interests, sports, hobbies)
_____
What is a realistic goal that you would like to achieve with therapy?
_____

MEDICAL HISTORY

Do you have, or have you had any of the following conditions?

- ☐ Arthritis / Osteoporosis (Where: _____)
- ☐ Blood clots
- ☐ Blood disease: (_____)
- ☐ Cancer (Type: _____ _____)
- ☐ Diabetes: Pills / Insulin / Diet controlled
- ☐ Drug-resistant infection / MRSA
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Head injury (Date: _____)
- ☐ Heart condition: (_____)
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Immune disorder: (_____)
- ☐ Kidney disease / Dialysis
- ☐ Liver disease / Hepatitis
- ☐ Lung disease: (_____)
- ☐ Lymphedema (Where:_____)
- ☐ Multiple Sclerosis
- ☐ Spinal cord injury (Date: _____)
- ☐ Stroke / TIA (Date: _____)
- ☐ Thyroid disorder: Hypo / Hyper
- ☐ Hearing problem (_____)
- ☐ Memory problem (_____)
- ☐ Speech / swallowing problem
- ☐ Vision problem (_____)

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Do you have, or have you had any of the following conditions?

- ☐ Allergies
- ☐ Pelvic Inflammatory Disease
- ☐ Blood in the Stool (currently)
- ☐ Rectocele
- ☐ Prolapse
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Urinary Incontinence/Leakage
- ☐ Chronic Constipation
- ☐ Pelvic Fractures
- ☐ Urinary Tract Infections
- ☐ Blood in the Urine (currently)
- ☐ Cystocele
- ☐ Hemorrhoids
- ☐ Interstitial Cystitis
- ☐ Ovarian Cysts
- ☐ Fecal Incontinence/Leakage
- ☐ Irritable Bowel Syndrome
- ☐ Chronic Diarrhea
- ☐ Coccyx Fractures

- Do you smoke? YES / NO Packs/day:_____
- Do you have a history of falls? YES / NO Date of last fall:_____

  How & where did you fall? _____

Please list any surgeries that we should be aware of:

_____

_____

Please list current medications with dosages: ☐ No current medications

_____

_____

_____

Please list any allergies to medications, adhesives, or latex: ☐ No known allergies

_____

_____

Have you received any other therapy services this year? (Include nursing home, home health, etc.)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy Where: _____

Are you currently pregnant? _____ Are you currently attempting pregnancy? _____

Are you currently sexually active? _____ Are you pre or post menopause? _____

Have you ever used a pessary? _____

Please list any pregnancies and births in the table below:

Date	Delivery type vaginal vs C-section	Episiotomy or tearing?

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Date of your last pelvic or rectal exam: _____ Date of your last urinalysis:_____
Please list any other medical history / issues that we should be aware of:
_____

Incontinence Questions: (Please fill this section out if you have any, even occasional, problems with urine or fecal incontinence or leakage.)

On average, I will leak _____ times per day/week/month (circle one).
I have leakage of (circle one): urine, feces
I wear the following protection (circle one): No protection, panti-shields, mini pad, maxi pad, diaper/Serenity. I change this protection _____ times per day.
Usually I will have the following amount of leakage (circle one): No leakage, a few drops, wet or soiled underwear, wet or soiled outerwear.
I usually leak with (circle all that apply): cough/sneeze, running, standing up, sexual activity, immediately after urinating, immediately after having a bowel movement, with the sound of running water, when I first get home, when I have a strong urge and just can't make it to the bathroom, vigorous activity, moderate activity, light activity,
other_____
Do you have a family history of incontinence or prolapse? _____
Do you have a "falling out feeling" or a feeling of heaviness or pressure in the pelvic floor?_____
How often do you urinate on an average day? _____
How often do you rise at night to urinate? _____
How long can you delay the need to urinate?_____
How many ounces of fluid do you drink each day (guess)_____
How many ounces of caffeinated beverages each day? _____
How often do you have a bowel movement? _____
Do you have trouble initiating the stream of urine? _____
Do you feel as if you empty your bladder completely? _____
Have you ever been taught how to do pelvic floor or Kegel exercises? _____
If so, how often are you doing them now? _____

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Pelvic Pain Questions: (Please fill out this section if you have problems with pain in the pelvic, abdominal, vaginal, or anal areas.)

Using the pain scale below, please rate your pain between 0-10:

_____ Pain today

_____ Lowest pain in the past few days / weeks

_____ Highest pain in the past few days / weeks

Rating	Description
0	No pain; no limitations due to pain
1 - 2	Pain is there but is low in intensity and is manageable; no observed limitations due to pain
3 - 4	Require more breaks, slowed work rate, slowed or altered movements, lean on nearby surfaces, limp
5 - 6	Needing to stop the activity you are currently performing, unable to maintain body position, very restricted movement
7 - 8	Tearful, needing to lie down, needing to take extra medications, difficulty engaging in conversation
9 - 10	Immediate emergency, hospitalization, unable to speak, incapacitated, worst pain imaginable

Where is the pain located? List:

_____

_____

Is the pain constant or intermittent (circle one).

If the pain is intermittent, what percentage of the time do you have pain? _____

When did your pain begin: _____

Is there something that you believe caused this pain to arise? If so, please describe._____

_____

_____

What makes your pain worse (circle any that apply): urination, bowel movement, intercourse/penetration, physical activity, positions (list)_____, menstruation, other

_____

_____

What makes your pain better (list) _____

_____

Do you also have buttock, low back, thigh, or leg pain? _____

General Questions: (everyone please complete)

Any other comments or concerns not asked?

_____

_____