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

<table>
<thead>
<tr>
<th>Date</th>
<th>Delivery type</th>
<th>Episiotomy or tearing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>vaginal vs C-</td>
<td></td>
</tr>
<tr>
<td>section</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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? __________________________
**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:**

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

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?
__________________________________________________________________________
__________________________________________________________________________