

Pelvic Floor Questionnaire

1. Name _____ 2. Date _____

3. History of Present Condition

Describe current symptoms _____

Length of time with problem _____

What increases your symptoms? _____

What decreases your symptoms? _____

Are there any activities you are avoiding because of this? _____

4. Obstetric History

Number of pregnancies _____ Number of C-sections _____

Number of vaginal deliveries _____

Date(s) and delivery weight(s) _____

Any complications? _____

Did you have incontinence during or after pregnancy? _____

5. Gynecologic History

Have you gone through menopause? _____ If yes, when? _____

Date of last pelvic exam _____ Date of last urinalysis _____

Any history of Cystitis (urinary tract infection)? _____ When was the most recent episode? _____

Are you sexually active? Yes _____ No _____

Are you pregnant or attempting pregnancy? Yes _____ No _____

History of sexually transmitted diseases? _____ Type _____

Pain or problems with intercourse? _____

Pain with urination? _____ Problems with bedwetting? _____

Have you ever been taught how to do pelvic floor or Kegel exercises? _____

When? _____ By Whom? _____

How often do you do them? _____

Any history of low back pain? _____ When was the most recent episode? _____

How much caffeine do you drink per day (coffee, tea, soda)? _____

Alcohol per day? _____

Incontinence or Prolapse Patients

6. Occurrence of Incontinence or leakage (if this does not apply, skip to question #12)

- Never (6)
- Less than 1/month (5)
- More than 1/month (4)
- Less than 1/week (3)
- More than 1/week (2)
- Almost every day (1)
- More than 1/day #_____ (0)

8. Severity

- No leakage (3)
- Few drops (2)
- Wet underwear (1)
- Wet outerwear (0)

10. How Long Can You Delay the Need to Urinate?

- Indefinitely (6)
- 1+ hours (5)
- ½ hour (4)
- 15 minutes (3)
- Less than 10 minutes (2)
- 1-2 minutes (1)
- not at all (0)

12. Prolapse (falling out feeling)

- Never (5)
- Occasionally/with menses (4)
- Pressure at the end of the day (3)
- Pressure with straining (2)
- Pressure with standing (1)
- Perineal pressure all day (0)

13. Frequency of Urination (Daytime)

- 0 times per day
- 1-4
- 5-8
- 9-12
- 13+

15. Fluid Intake

- 9+ 8 oz. glasses per day
- 6-8 8 oz glasses per day
- 3-5 8 oz glasses per day
- 1-2 8 oz glasses per day
- How many caffeinated glasses? _____

17. After starting to urinate, can you completely stop the urine flow?

- Can stop completely (3)
- Can maintain a deflection of the stream (2)
- Can partially deflect the urine stream (1)
- Unable to deflect or slow the stream (0)

18. Do you have trouble initiating a urine stream?

- Never (3)
- More than 1/month (2)
- Less than 1/week (1)
- Almost every day (0)

19. Attitude towards problem

- No problem (4)
- Minor inconvenience (3)
- Slight problem (2)
- Moderate problem (1)
- Major problem (0)

7. Protection Worn

- No protection (4)
- Pantishields (3)
- Mini Pad (2)
- Maxi Pad (1)
- Diaper/Serenity (0)

9. Position or Activity with Leakage

- Lying down
- Sitting
- Standing
- Changing positions (sit to stand)
- Intercourse
- Strong urge

11. Activity That Causes Urine Loss

- Vigorous Activity (3)
- Moderate activity (2)
- Light activity (1)
- No activity (0)

14. Frequency of Urination (nighttime)

- 0 times per night
- 1
- 2
- 3
- 4+

16. Frequency of Bowel Movements

- 2 times per day
- 1 time per day
- every other day
- once every 4-7 days
- weekly
- other

20. Confidence in controlling your problem

- Complete confidence (3)
- Moderate confidence (2)
- Little confidence (1)
- No confidence (0)