

Female Pelvic Floor Intake Questionnaire

Name: _____ **Date:** _____
DOB: _____

Reason for Referral _____

When did the problem begin? _____

RELEVANT HISTORY

Medical History (Fill in background information on the following by checking all that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Recurrent muscle or joint pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Circulation Disease |
| <input type="checkbox"/> Respiratory Dysfunctions | |

Gynecological History (Please provide information on any of the following that apply to you:)

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have your menstrual periods stopped? |
| <input type="checkbox"/> | <input type="checkbox"/> | On hormone replacement therapy? If yes, which one? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do/did you have pain with your menstrual periods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do/did you have pain with intercourse? If yes, with initial penetration or deep penetration? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Cysts |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Inflammation Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibroids |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Pain |

GYN Surgeries:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Laparoscopy |

Obstetrical History: (for each of your children, provide as much information as possible)

Birth Date	Weight	Vaginal/Cesarean	Prolonged Pushing?	Tearing/Forceps/episiotomy

Personal History: (please provide as much information as possible)

Regular Exercise _____
 Dietary Habits (meat, fruit, veggies, fiber) _____
 Caffeine Intake (coffee, tea, soda) _____
 Fluid Intake/Day (water, juice, milk) _____
 Sleep Habits (trouble falling asleep, staying asleep, reason for awakening, rested in AM, use of medications to sleep?) _____
 Sexual Activity _____
 Social _____ Limitations? _____
 Work _____
 Life Style Sedentary Or Active (please circle one) _____
 Travel _____

Special Diagnostic Tests: (please check)

- EMG
- MRI
- Cystoscope
- Bladder Stress Test
- Colonoscopy
- Pudendal Nerve Test
- Anal Ultrasound - Manometry
- Defecation Proctogram Study
- Urodynamic testing

BOWELS HABITS

Form (small/hard, loose, soft/long) _____

Bowel Habits (frequent, any laxatives, etc.)

Do you strain to have BM? _____
 BM Frequency times/day _____ time/week _____
 Toileting Position _____ Splinting Y/N _____ %

Bowel Incontinence Symptoms:

Fecal Leakage _____ episodes per day _____ week _____ month _____ other _____
 Leakage Amount _____ Pads/day _____
 Gas Control? Y/N _____ Other _____

BLADDER QUESTIONNAIRE Please answer these questions to the best of your ability

	Never	Sometimes	Often
1. Do you leak urine when you cough, sneeze, laugh or when lifting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever have such an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If "yes" to question #2, do you ever leak before you reach the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you wet the bed in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have an urge to urinate when you hear running water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have an urge to urinate when your hands are in water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you ever leak during or after sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you find it necessary to wear a pad because of leaking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If "yes" to question #9, how many pads a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had bladder, urinary or kidney infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you troubled by pain or discomfort when you urinate or BM?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had blood in your urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you find it hard to begin to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a slow urine stream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you strain to pass your urine or BM?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. After you urinate, do you have dribbling or a feeling that your bladder is still full?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. After BM, do you feel an incomplete emptying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have burning when you void?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE TRY TO GIVE ACTUAL NUMBERS

	Number of times
20. How many times during the day do you urinate?	_____
21. How many times do you void during the night after you go to bed?	_____
22. How often do you leak?	_____
23. Leakage equals: Small (less than one-half cup)	_____
Large (more than one-half cup)	_____
24. How much warning time do you have to get to the toilet? Seconds or Minutes	_____

Pelvic Girdle Pain:

Do you use tampons or pads for menses? _____
 Are you sensitive to soaps, perfumes, deodorants or laundry detergents? _____ Yes _____ No
 Rate your pain on the 0-10 scale (10 being the worse, ER visit necessary; 0-No pain):
 _____ Best _____ Average _____ Worst
 What activities make the pelvic pain worse? _____
 What activities relieve the pelvic symptoms? _____