Virginia Urology

Female Pelvic Floor Intake Questionnaire

Date: _____

Name: _____ **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)

- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Thyroid Condition
- ❑ Respiratory Dysfunctions
- ❑ Recurrent muscle or joint pain
- ❑ Breathing Problems
- ❑ Circulation Disease

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

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

GYN Surgeries:

- ❑ Hysterectomy
- ❑ C-Section
- ❑ Gall Bladder
- ❑ Appendectomy
- ❑ Hernia
- ❑ 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?	❑	❑	❑
2. Do you ever have such an uncomfortable, strong need to urinate that if you don't reach the toilet you will leak?	❑	❑	❑
3. If "yes" to question #2, do you ever leak before you reach the toilet?	❑	❑	❑
4. Have you wet the bed in the past year?	❑	❑	❑
5. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry?	❑	❑	❑
6. Do you have an urge to urinate when you hear running water?	❑	❑	❑
7. Do you have an urge to urinate when your hands are in water?	❑	❑	❑
8. Do you ever leak during or after sexual intercourse?	❑	❑	❑
9. Do you find it necessary to wear a pad because of leaking?	❑	❑	❑
10. If "yes" to question #9, how many pads a day?	❑	❑	❑
11. Have you had bladder, urinary or kidney infections?	❑	❑	❑
12. Are you troubled by pain or discomfort when you urinate or BM?	❑	❑	❑
13. Have you had blood in your urine?	❑	❑	❑
14. Do you find it hard to begin to urinate	❑	❑	❑
15. Do you have a slow urine stream?	❑	❑	❑
16. Do you strain to pass your urine or BM?	❑	❑	❑
17. After you urinate, do you have dribbling or a feeling that your bladder is still full?	❑	❑	❑
18. After BM, do you feel an incomplete emptying?	❑	❑	❑
19. Do you have burning when you void?	❑	❑	❑

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? _____

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