BOZEMAN HEALTH
DEACONESS HOSPITAL

Quest

Patient Label
Name: _____
DOB: _____
M#: _____

PELVIC FLOOR SYMPTOM QUESTIONNAIRE

Please fill in the following questionnaire to the best of your ability. Your therapist will review the answers with you during your appointment.

When did you symptoms first begin?_____

Was your first episode related to a specific incident? NO / YES – specify _____

Are your symptoms – Same ____ Getting Worse _____ Getting Better ____

Goal for physical therapy _____

Males please fill out the following questions:

Have you had a prostate exam within the last 12 months? YES / NO

Do you have erectile dysfunction? YES / NO

Do you have prostate disease? YES / NO If yes – please specify _____

Do you have a history of sexual abuse or trauma? YES / NO

Do you have testicular pain? YES / NO

Do you have back, leg, groin or abdominal pain? YES / NO

Please rate your pain – 0 1 2 3 4 5 6 7 8 9 10

If pain present - please check the following words that describe your pain –

___ Burning ___ Aching ___ Stinging ___ Numbness ___ Hot ___ Stabbing ___Tingling

___ Other – please specify _____

Do you have urinary incontinence YES / NO Fecal Incontinence YES / NO

Constipation YES / NO Strain with Bowel Movements NO / SOMETIMES / ALL THE TIME

Pertinent Surgical History – please specify _____

Females please fill out the following questions:

Childbearing History

Are you currently pregnant? YES / NO

Number of pregnancies:_____ Number of vaginal deliveries: _____ Number of cesarean deliveries ____

Number of episiotomies:_____ Did you have trouble after delivery? YES / NO

Birth weight of largest baby: _____

Pain

Do you have pain with sexual intercourse? YES / NO

Do you have pain with pelvic examination? YES / NO

Do you have pain with tampon use? YES / NO

Do you have back, leg, groin or abdominal pain? YES / NO

Please rate your pain – 0 1 2 3 4 5 6 7 8 9 10

If pain present - please check the following words that describe your pain –___ Burning ___ Aching ___ Stinging ___ Numbness ___ Hot ___ Stabbing ___Tingling ___ Other – specify _____

Gynecologic History

Date of last pap smear ___/___/___

Are you having regular periods/menstrual cycles? YES / NO

Do you have a history of sexual abuse? YES / NO

Do you have a history of trauma? YES / NO

Do you have a history of frequent yeast infections? YES / NO

(more than 2 per year)

Do you experience a sensation of pelvic pressure or "falling out"? YES / NO

If yes: Related to standing or walking _____ With exertion/straining _____

During menstrual cycle _____ Other- specify _____

GYN/Abdominal Surgery – please specify _____

<u>Previous Treatment (males and females):</u>

Urodynamics Cystoscopy

Urine testing Bowel Testing

<u>Bladder Symptoms (males and females):</u>

Average fluid intake (one glass = 8 oz cup) per day _____

Of these, how many are caffeinated? _____

How often do you urinate per day? <5 times 5-8 times >8 times

How much urine is typically voided? Trace ___, small ___, medium___, large ___

How often do you get up at night to urinate? _____

How long can you delay the urge to urinate? _____

Do you have the urge to urinate without warning (urinary urgency)? YES / NO

Do you wet the bed? YES / NO

Having burning/pain with urination? YES / NO

Difficulties with starting the flow of urine? YES / NO

Strain to empty your bladder? YES / NO

Feel unable to fully empty your bladder? YES / NO

Have pain with full bladder? YES / NO

Do you have frequent urinary/bladder infections? YES / NO

(more than 2 per year)

Do you have urinary leakage? YES / NO

How often? Daily ____ Weekly ____ Intermittent____

How much urine is leaked? Trace ___ , small___, medium___, large___

What causes leakage?

Strong urge to go: ____ Light Activities: _____ Walking to the toilet: ____

Changing Positions: ____ Cough/Sneeze/Laugh: _____ Vigorous Activity/Exercise: _____

Sexual activity: _____ Hearing running water _____ Unknown: _____

Other – please specify: _____

What type of protection do you wear? _____

On average, how many times do you change your protection per 24 hours? _____

Bowel Symptoms (males and females):

How often do you have a bowel movement? _____ Day / Week

When you have the urge to go, how long can you delay before going to the toilet?

Unable _____ Seconds _____ Minutes _____ Hours _____

Do you strain to have a bowel movement? YES / NO

Do you include fiber in your diet? YES / NO

Take laxatives/enemas regularly? YES / NO

How often _____?

Do you have painful bowel movements? YES / NO

Do you often have diarrhea? YES / NO

Leak gas/air by accident? YES / NO

Most common stool consistency?

Liquid ____ Soft ____ Firm____ Pellets____ Other – specify _____

Do you have bowel leakage/accidents? YES / NO

If yes, how often? _____

How much is leaked? Trace____ Small____ Medium____ Large____

Impact on Daily Living (males and females):

Affects my choice of clothing: _____ Affects my relationships/sexual activity with partner: _____

Affects my abilities for housework: _____ I withhold/restrict my fluid intake: _____

Cannot travel more than an hour without visiting bathroom: _____ I worry I smell: _____

Interferes with social activities (movies, dancing, church, visitors): _____ Affects my sleep _____

Interferes with my work life: _____ I feel anxious, depressed, embarrassed, frustrated or angry:_____

Interferes with recreational or physical activity: -_____

Other- please specify: _____