Name:_____DOB:_____Date:_____

PELVIC HEALTH QUESTIONNAIRE

Answering the following questionnaire will help us to identify all of the potential problems that often accompany pelvic/abdominal/bowel/bladder/sexual dysfunction. Feel free to mark NA for items that do not apply to you, and to add anything relevant you feel we should know. Thank you!

Date of Last Dr. Visit:_____Next Dr. Visit:_____Last Pelvic Exam:_____Urinalysis:_____

Describe the reason for your appointment and when the problem started:

Please list all your current health care providers and their specialties below:

Previous tests for the condition that brings you to Physical Therapy:

Is your condition/problem? ☐ Getting Worse ☐ Getting Better ☐ Staying the Same

General Medical History (*Check all that apply*):

☐ Cancer	☐ Pacemaker	☐ Osteoporosis
☐ Cardiac History	☐ Head/Brain Injury	☐ Back Pain/Sciatica
☐ High/Low Blood Pressure	☐ Arthritis/Rheumatologic	☐ Anxiety/Depression

Other and details regarding above:

List any surgeries, current or past medical diagnosis/ conditions and approximate date

Medical Diagnosis/Surgery	Date

List any medications (prescription and over-the-counter) you are currently taking and the reason you're taking it

☐ *See Electronic Medical Record* ☐ *See attached list*

Medication	Reason	Medication	Reason

Additional:

Occupation: _____ Are you working? ☐ Yes ☐ No Restrictions? _____

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List 3 activities affected because of your problem (*i.e. Voiding Difficulty, Physical Activity, Work, Sexual Issues):*

1. _____
2. _____
3. _____

History of physical or emotional abuse or sexual trauma? ☐Yes ☐ No ☐Past

Females Only:

☐ History of endometriosis	☐ Vaginal dermatological condition
☐ History of cysts or fibroids	☐ Vaginal dryness
☐ Pelvic inflammatory disease	☐ Pregnant or attempting pregnancy
☐ Painful menstrual cycle	☐ History of difficult childbirth/s
☐ Menopause	Approximate date of last period: _____

# of Pregnancies: _____ Stillborns: _____ Miscarriages: _____ Abortions: _____

Delivery Date	Vaginal?	C-Section?	Full Term?	Premature?	Birth Weight	Age Now?

Did you require?

☐Forceps ☐Vacuum ☐ Assist with delivery

Please share any other information regarding childbirth trauma: _____

Have you been diagnosed with prolapse or descent of bladder, bowel, uterus, or other?

☐ Yes ☐ No

Have you had previous surgery for prolapse?

☐ Yes ☐ No

Do you currently use, or have you ever used a pessary?

☐ Yes ☐ No

Is there a sensation of "falling out" or pelvic pressure/heaviness?

☐ With lifting	☐ With standing	☐ Worse during period	☐ Worse end of day
☐ During or post exercise	☐ With bending	☐ Randomly	☐ See/feel vaginal bulge
☐ With exertion	☐ With straining	☐ Present every day	☐ Part of rectum bulges

Males Only:

Do you currently have, or have you ever had a history of the following?

☐ Prostate Cancer	☐ Chronic Prostatitis
☐ Prostate Removal Date:	☐ Painful Erections/Ejaculation
☐ Radioactive Seeds	☐ Erectile Disorder
☐ BPH (Enlarged Prostate)	☐ Peyronies Disease
☐ TURP Surgery Date:	☐ Other_____

Please share any other relevant information regarding your medical history:

_____

Name:_____DOB:_____Date:_____

Bladder:

Pelvic Health History - *Do you have now or past history of?*

☐ Bladder infections # per past year_____	☐ Trouble initiating urine stream
☐ Yeast infections # per last year _____	☐ Trouble emptying bladder
☐ Urinary incontinence (leaking of urine)	☐ Slow urine stream
☐ Painful urination	☐ Dribbling of urine
☐ Urinary urgency	☐ Shy bladder
☐ Urinary frequency	☐ Childhood bladder problems

Bladder leakage frequency – Number of episodes:

_____# per month ____# per week ____# per day ____ Constant leak ____ Varies

Leakage experienced with:

☐ Vigorous activity/exercise	☐ With strong urge
☐ Coughing/sneezing	☐ On the way to toilet
☐ Laughing	☐ Rushing
☐ Changing position (i.e. sit to stand, bending)	☐ When nervous or anxious
☐ Intercourse/sexual activity	☐ Key in the Door
☐ Light activity (walking, housework)	☐ When you are cold
☐ Other _____	☐ When you hear running water

Severity of Leakage:

☐ Few drops ☐ Wet underwear ☐ Wet outerwear ☐ Varies

Leakage Occurs:

☐ During day ☐ During sleep ☐ Only with activity ☐ Cannot feel it happening

Protection worn:

☐ Tissue paper ☐ Pantyliner ☐ Menstrual pad ☐ Incontinence pad ☐ Depends

Protection product is:

☐ Damp ☐ Wet ☐ Saturated ____# Used per 24-hour period

Urination frequency:

How often do you empty your bladder during awake hours? _____ During sleep hours? _____

How long can you delay the need to urinate once you have experienced the urge to use the bathroom?

☐ Not at all ☐ 1-2 minutes ☐ 3-10 minutes ☐ 11-30 minutes ☐ 31-60 minutes

Do you have a sensation or urge to urinate?

☐ Yes ☐ No ☐ Sometimes

Do you frequently empty your bladder before you experience the urge to go?

☐ Yes ☐ No ☐ Sometimes

Can you stop the flow of urine when on toilet to give a "clean catch" sample?

☐ Yes ☐ No ☐ Sometimes

Please list any "trigger" or situation which makes you feel stronger urge?

How many ounces or cups of fluid do you drink in average day?_____

How many ounces or cups are caffeinated or alcoholic (diuretic)?_____

Name:_____DOB:_____Date:_____

Bowel

Pelvic Health History: *Do you have now or past history of?*

☐ Gastrointestinal problems	☐ Fecal incontinence (leak or seep stool)
☐ Irritable Bowel Syndrome	☐ Gas incontinence (involuntary loss of gas)
☐ Inflammatory Bowels Disease, such as Crohn's	☐ Frequent need to strain to pass stools
☐ Abdominal pain	☐ Painful or difficulty with bowel movements
☐ Problems with diarrhea	☐ Hemorrhoids
☐ Problems with constipation	☐ Fissures
☐ Recurrent nausea or vomiting	☐ Trouble feeling bowel fullness or urge
☐ Loss of appetite	☐ Excessive gas from rectum
☐ Chronic indigestion or reflux	☐ Excessive belching
☐ Problem with abdominal bloating	☐ Excessive mucous from rectum

Frequency of bowel movements:

_____# per day ____# per week ☐ Use stool softener, laxatives or enema (please circle)

What is your lifelong habit of bowel frequency?

_____Has it Changed? ☐ Yes ☐ No

Bowel leakage frequency – Number of episodes:

_____# per month ____# per week ____# per day ☐ Varies

Severity of leakage:

☐ Smear in underwear ☐ Small amount or pellet ☐ Medium or large amounts ☐ Varies

Type of leakage:

☐ Solid ☐ Soft ☐ Liquid ☐Combination

Is loss of stool associated with activity? ☐ Yes ☐ No ☐ Sometimes

Can you tell if there is solid, gas, or liquid in rectum? ☐ Yes ☐ No ☐ Sometimes

Do you strain to pass stool? ☐ Yes ☐ No ☐ Sometimes

Do you feel the urge to defecate? ☐ Yes ☐ No ☐ Sometimes

Do you ignore the urge to defecate? ☐ Yes ☐ No ☐ Sometimes

Do you feel you have fully emptied your bowels with each BM? ☐ Yes ☐ No ☐ Sometimes

Do you have to digitally assist or use enemas or suppositories? ☐ Yes ☐ No ☐ Sometimes

Do you awaken with urge during sleep hours? ☐ Yes ☐ No ☐ Sometimes

Do you have rectal pain, pressure, or burning? ☐ Yes ☐ No ☐ Sometimes

Do you use a "Squatty Potty®"? ☐ Yes ☐ No ☐ Sometimes

Do you take a fiber supplement and/or probiotic? ☐ Yes ☐ No

Please List: _____

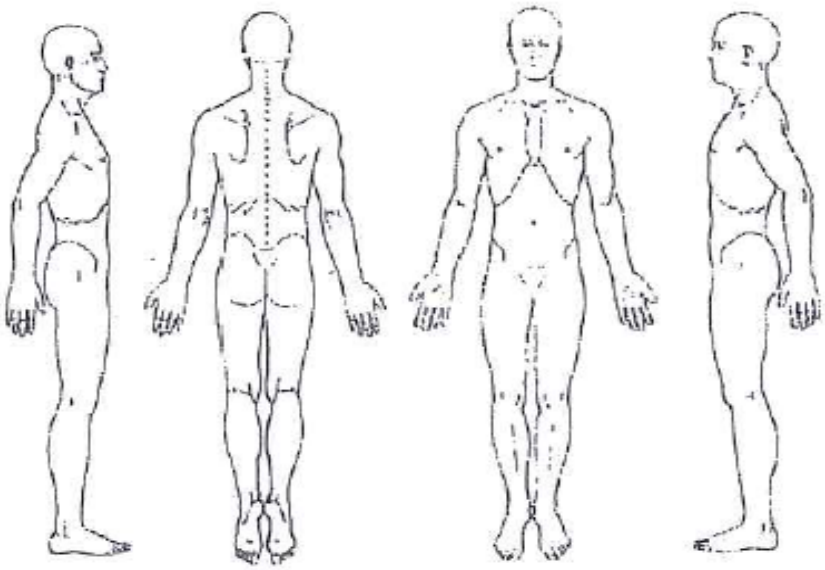
How many servings of fiber do you eat daily?

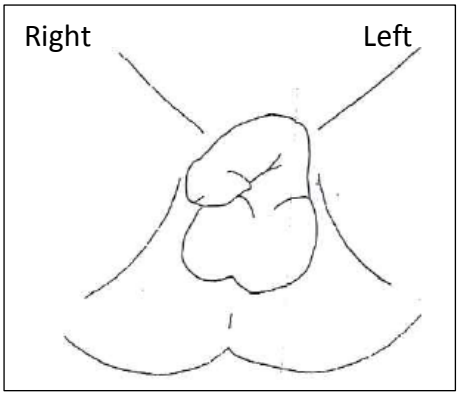
_____

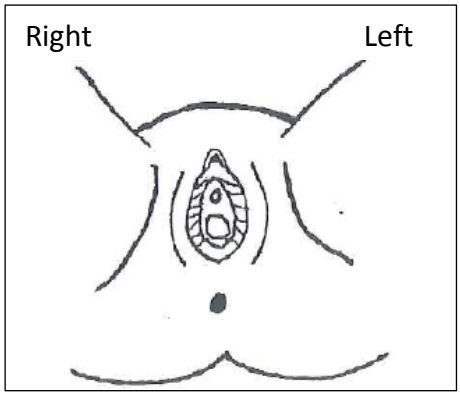
Name:_____DOB:_____Date:_____

Pain or Other Symptoms

Current symptoms: Please mark the diagram/s in the areas affected using: X = Pain T = Tingling. N = Numbness B = Burning







Pain Rating 0 – 10 With 0 being no pain & 10 being the worst pain

Current pain level: _____ Pain at best: _____ Pain at worst: _____

Pelvic pain?
☐ Yes ☐ Sometimes ☐ Past

Perineal pain?
☐ Yes ☐ Sometimes ☐ Past

Vulvar pain? Or burning or itching?
☐ Yes ☐ Sometimes ☐ Past

Anal pain? Or burning or itching?
☐ Yes ☐ Sometimes ☐ Past

Rectal pain?
☐ Yes ☐ Sometimes ☐ Past

Vaginal Pain?
☐ Yes ☐ Sometimes ☐ Past

Tailbone or coccyx pain?
☐ Yes ☐ Sometimes ☐ Past

Bladder pain?
☐ Yes ☐ Sometimes ☐ Past

Abdominal pain?
☐ Yes ☐ Sometimes ☐ Past

Groin pain?
☐ Yes ☐ Sometimes ☐ Past

Lumbar or sacral or SIJ pain?
☐ Yes ☐ Sometimes ☐ Past

Hip, buttock or thigh pain?
☐ Yes ☐ Sometimes ☐ Past

Please list any comments about your pain or other areas of pain/symptoms:

_____

_____

Name:_____DOB:_____Date:_____

Sexual Health

Are you sexually active?
☐ Yes ☐ No ☐ In Past

Do you have trouble achieving orgasms?
☐ Yes ☐ No ☐ Sometimes

Pain or symptoms with intercourse or sexual activity?
☐ Yes ☐ No ☐ Sometimes

Do you struggle with low sexual desire?
☐ Yes ☐ No ☐ Sometimes

Sexually Transmitted Infections (STIs/STDs)
☐ Yes ☐ No ☐ Past

Further explanation of any of above responses or add other information you wish to share: