Pelvic Floor Questionnaire

Name _____ DOB _____ Age _____
Date _____

1. What is the current problem that brought you here?

   _____

2. When did this problem begin?_____
3. Is this related to a specific incident or trauma? If so, please describe.

   _____

4. Since this started is the problem worsening, improving, or staying the same? _____
5. Do you have pain? If so, please rate 0-10 (10 is worst pain) and describe

   _____

6. Have you had previous treatment/exercise? _____
7. What aggravates your symptoms? Check which ones apply

Sitting greater than ___ minutes	Coughing/sneezing/ straining	Walking greater than ___ minutes
Changing positions	Light Activity	Vigorous Activity
Sexual Activity	Laughing	Lifting/bending
Anxiety/nervousness	No specific activity	Other:

8. What relieves your symptoms?

   _____

9. Has this altered your quality of life and how so?

   _____

10. What are your treatment goals?

    _____

11. Since the onset of your symptoms have you experienced? Circle

Change in bowel/bladder functions	Unexplained muscle weakness
Numbness/tingling	Night pain/sweats
Dizziness/fainting	Other

12. When was your last physical exam and what tests were performed?

    _____

13. General Health: Good Average Fair Poor
14. Occupation _____
    a. Hours/week _____ b. Disability/leave _____ Restrictions? _____
15. Activity/Exercise: None 1-2 days/wk 3-4 days/wk 5+ days/wk
    a. Describe
16. Current Stress Level: High Med Low
    a. Any current psych therapy/meds?_____
17. Have you experienced the following conditions or diagnoses? Circle

Cancer	Chronic bronchitis	Heart Problems
High blood pressure	ankle swelling	Anemia
Hyperthyroid	Low back pain	Tailbone pain
Alcoholism/Drug dependency	childhood bladder problems	bowel syndrome
depression	anorexia/bulimia	Smoking history
stroke	epilepsy/seizures	Multiple Sclerosis
Head Injury	Osteoporosis	Fibromyalgia
Arthritis	Fractures	Acid reflux
Joint replacement	Emphysema	Asthma
Allergies	Headaches	Diabetes
Kidney Disease	Irritable Bowel Syndrome	Hepatitis
Sexually Transmitted Disease	Physical or Sexual abuse	Pelvic Pain

18. Please list ALL your previous surgeries

    _____
    _____
    _____

19.

Vaginal deliveries #	Episiotomy #	Vaginal Dryness?
C-Section #	Painful Periods?	Menopause? When?
Prolapse?	Painful Intercourse?	Pelvic/genital pain?

20. Medications (include over the counter):

_____
_____
_____
_____

Bladder/Bowel Habits/Symptoms	Yes	No
Trouble initiating urine stream		
Urine stream slow/intermittent		
Strain/push to empty bladder		
Inability to empty bladder		
Blood in Urine		
Urine leakage		
Difficulty feeling bladder urge/fullness		
Recurrent bladder infections		
Painful urination		
Blood in stool/feces		
painful bowel movements		
Difficulty feeling bowel urge/fullness		
Seepage/loss of BM		
Trouble holding back gas		
Constipation/Straining to empty bowel		
Need to support/touch to complete BM		
Staining of underwear after BM		
Use of laxative		