P E L V I C H E A L T H Q U E S T I O N N A I R E

Name _____ Gender Identity: _____Age _____ Date _____

1. **Describe the current problem that brought you here?**

2. When did your problem first begin? _____.

3. Was your first episode of the problem related to a specific incident? YES / NO

   Please describe and specify date _____

Since that time is it: □staying the same □getting worse □getting better

Why or how?

What relieves your symptoms?

4. Activities/events that cause or aggravate your symptoms. *(Check all that apply)*
   - □ Sitting greater than _____ minutes
   - □ Walking greater than _____ minutes
   - □ Standing greater than _____ minutes
   - □ Changing positions (i.e. - sit to stand)
   - □ Light activity (light housework)
   - □ Vigorous activity/exercise (run/weight lift/jump)
   - □ With nervousness/anxiety
   - □ With cough/sneeze/straining
   - □ With laughing/yelling
   - □ With lifting/bending
   - □ With cold weather
   - □ With triggers -running water/key in door
   - □ Other. Please list:

5. If pain is present, rate pain on a 0-10 scale. 10 being the worst. _____. Describe the nature of the pain and location (i.e. constant burning, intermittent ache):

6. Date of last medical exam for this issue:

7. Tests performed for current complaint:

8. Describe previous treatment/exercises for current symptoms:

9. Check all that apply: □ currently pregnant □ active urogenital infection

   □ Surgery in past 2 months □ Sexually Transmitted Infection

10. **What are your treatment goals/concerns?**

Uterine & Vaginal Health

Number of pregnancies ____	Y / N Negative sexual experience
Vaginal deliveries #_____ C-Section #_____	Y / N Pelvic pain
Y / N Vacuum/forceps delivery	
Y / N Episiotomy/tearing_____	Y / N Painful periods
Y / N Menopause When? _____	Y / N Vaginal dryness
Y/ N Surgery for your pelvic organs	Y / N Prolapse or organ falling out
Y / N Hormone Therapy. If so, explain:	

Penile & Prostate Health

Y / N Prostate disorders	Y / N Negative sexual experience
Y / N Pelvic Pain	Y / N Erectile dysfunction
Y / N Other. Describe:	Y / N Painful ejaculation
Y / N Hormone Therapy. If so, explain:	Y / N Surgery for your pelvic organs

Name _____ **MR#**_____ **Age** _____ **Date** _____

PELVIC SYMPTOM QUESTIONNAIRE

Bladder / Bowel Habits / Problems:

Y / N Trouble initiating urine stream
Y / N Urinary intermittent /slow stream
Y / N Trouble emptying bladder
Y / N Difficulty stopping the urine stream
Y / N Straining or pushing to empty bladder
Y / N Dribbling after urination
Y / N Constant urine leakage
Y / N Other. Describe:

Y / N Painful urination
Y / N Trouble feeling bladder urge/fullness
Y / N Current laxative use
Y / N Trouble feeling bowel/urge/fullness
Y / N Constipation/straining
Y / N Trouble holding back gas/feces
Y / N Recurrent bladder infections

1. **Frequency of urination**:

   Waking Hours: Number of urinations/day_____ Sleeping Hours: Number of urinations/night ____

   When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   minutes ___ hours ___ not at all ____

2. **Frequency of bowel movements:**

   times/day ____ or times/week ____

   When you have a bowel movement urge, how long can you delay before you have to go to the toilet? ____ minutes, ___ hours, ___ not at all

3. If constipation is present, describe management techniques:

4. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
   - ___ None present
   - ___ Times per month (specify if related to activity or your period)
   - ___ With standing for ___ minutes or ___hours
   - ___ With exertion or straining
   - ___ Other

5. Bladder leakage - number of episodes.
   - ___ No leakage
   - ___ Times per day
   - ___ Times per week
   - ___ Times per month
   - ___ Only with physical exertion/cough

   Bowel leakage - number of episodes
   - ___ No leakage
   - ___ Times per day
   - ___ Times per week
   - ___ Times per month
   - ___ Only with exertion/strong urge

6. On average, how much urine do you leak?
   - __ No leakage
   - __ Just a few drops
   - __ Wets underwear
   - __ Wets outerwear
   - __ Wets the floor

   How much stool do you lose?
   - __ No leakage
   - __ Stool staining
   - __ Small amount in underwear
   - __ Complete emptying

7. What form of incontinence protection do you wear? (Please complete only one)

Name _____ **MR#**_____ **Age** _____ **Date** _____

___ None
___ Minimal protection (Tissue paper/paper towel/panty shields)
___ Moderate protection (absorbent product, maxi pad)
___ Maximum protection (Specialty product/diaper)

8. How many pad changes required in 24 hour period due to incontinence?

Sexual Activity:

Are you currently sexually active? YES / NO

Is your current issue impacting your sexual activity? YES / NO

Do you have any pain, irritation, burning, and/or muscle spasm w/ penetration?
Where:

Dyspareunia is a medical term for painful penetration graded on three level, circle the level that applies:

Level 1: painful but with same frequency
Level 2: painful and limits frequency
Level 3: painful and prevents penetration

How long after intercourse do you have pain?

Do you use lubrication?

If so, what lubrication do you use?

What positions are comfortable?

What positions are uncomfortable?

Any history of sexual abuse or trauma? YES / NO

Diet and Fluid Habits:

Average **WATER** intake (*one glass is 8 oz. or one cup*) _____ glasses per day.

Average glasses: **coffee** ___ tea ____ **carbonated beverages** ____ **juices**____

alcoholic beverages____ **artificially sweetened** ___

When do you drink? Number of drinks: AM____ Afternoon_____ PM_____

Patient Specific Functional Scale:

How has your lifestyle/quality of life been altered/changed because of this problem?(*Social activities, Diet /Fluid intake, Physical activity, Work, Other*)

Please identify up to three important activities that you are unable to do, are having difficulty with, or poor quality of life as a result of your problem.

	Unable/difficult ←										→ Completely Able
1._____	0	1	2	3	4	5	6	7	8	9	10
2._____	0	1	2	3	4	5	6	7	8	9	10
3._____	0	1	2	3	4	5	6	7	8	9	10

Name _____ **MR#**_____ **Age** _____ **Date** _____

Patient Signature _____ Date _____

Therapist Signature _____ Date _____ Time _____