PELVIC HEALTH QUESTIONNAIRE

Full Name: ______________________________ Date of Birth: ____________________

URINARY SYMPTOMS

Yes	No	Do you have accidental loss of urine?
yr	mo	How many months or years have you had leakage of urine?
Yes	No	Do you wear pads for the urine leakage?
		If yes, what size pad do you wear? ____________
		How many pads do you wear in a day? ____________
		How many trips to the bathroom do you make during the day? ____________ (from the time you wake up in the morning until the time you go to sleep at night)
		How many times do you get up to urinate after you fall asleep? ____________
Yes	No	Does an uncomfortably strong need to pass urine wake you up?
Yes	No	Does the sound, sight or feel of running water cause you to lose urine?
Yes	No	Do you lose urine during coughing, sneezing, running or heavy lifting?
Yes	No	Do you lose urine with position changes, standing or walking?
Yes	No	Do you lose urine during the act of intercourse at penetration?
Yes	No	Do you lose urine during orgasm?
Yes	No	I lose urine all the time so I am constantly wet.
Yes	No	Do you notice any dribbling or urine when you stand after passing your urine?
Yes	No	Do you usually have difficulty starting your urine stream?
Yes	No	Have you ever required catheterization for the inability to pass your urine?
Yes	No	Do you ever feel that your bladder is not emptying completely after passing urine?
Yes	No	Have you seen any blood in your urine?
Yes	No	Do you have any burning with urination?
Yes	No	Have you had three (3) or more urinary tract infections in the last year?
Yes	No	Have you seen a physician for complaints of urine loss?
Yes	No	Have you had surgery to prevent urine loss?
Yes	No	Have you taken medicine to stop urine loss or for frequency or urgency to urinate?
		If yes, circle the medication **Detrol** **Oxybutynin** **Toviaz** **Ditropan** **Sanctura** **Myrbetriq** **Enablex** **Vesicare**
Yes	No	Other prior treatments, circle all: **Kegels** **Biofeedback** **Botox** **PTNS** **Interstim** **Physical therapy** **Other:** ____________

GENITOURINARY PROLAPSE (Women)

Yes	No	Do you have a bulge or mass in your vagina?
yr	mo	How many months or years have you had this bulge or mass?
Yes	No	Have you seen a doctor for this bulge or mass in your vagina?
Yes	No	Have you worn a pessary for this problem?
yr	mo	If yes, how many months or years have you worn this pessary?
Yes	No	Are you happy with the pessary?
Yes	No	Have you had surgery in the past for a bulge or mass in the vagina?

FECAL INCONTINENCE

Yes	No	Do you have accidental loss of solid stool?
Yes	No	Do you have accidental loss of liquid stool?
Yes	No	Do you have accidental loss of gas?
yr	mo	How many months or years have you had accidental loss of stool or gas?
Yes	No	Have you seen a doctor for this problem?
Yes	No	Did the problem with accidental loss of stool begin after childbirth?
Yes	No	Did you wear protective pads for this problem? If yes, what size pad do you wear? ________ How many pads do you wear each day? ________
Yes	No	Are you able to sense the need to have a bowel movement?
Yes	No	Are you able to tell the difference between solid stool/liquid stool/gas?
Yes	No	Do you have a frequent desire to have a bowel movement?
Yes	No	Do you feel that your bowels are never completely empty?
Yes	No	Have you had surgery for this problem?
Yes	No	Has there been a change in your bowel habits recently?
Yes	No	Have you noticed any bright red bleeding with your bowel movements?
Yes	No	Have you noticed black or "tarry" stools?
Yes	No	Are your bowel movements painful?

CONSTIPATION

Yes	No	Do you have constipation?
Yes	No	Do you excessively strain to pass stool more than 25% of the time?
Yes	No	Do you have less than three bowel movements each week?
Yes	No	Do you pass hard, small stool?
yr	mo	How many months or years have you had constipation?
Yes	No	Have you seen a doctor for this problem?
Yes	No	Do you use any medication or over the counter products for constipation? If yes, what have you used? ________
Yes	No	Have you had surgery for this problem?
Yes	No	Have you ever placed your hand or fingers in your vagina or between your vagina and rectum to help bring about a bowel movement? ________
Yes	No	Do you have a feeling of incomplete emptying after bowel movements?

SEXUAL HISTORY

Yes	No	Are you sexually active? If no, circle or fill in reason: **Pain Dryness Bladder issues No partner** ________
Yes	No	Do you have pain with sexual activity? If yes, please describe:
Yes	No	Has this been addressed in the past? If yes, what was the treatment: ________

Is there anything else we should know but did not ask? Please write below.

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