PHYSIOTHERAPHY NEW MEXICO
9 Frasco Way
Santa Fe, NM 87508

PELVIC FLOOR QUESTIONNAIRE

PATIENT NAME:_____ **PHYSICIAN:**_____ **DATE:**_____

Describe your main problem: _____

_____

When did it begin?_____ ***Is it getting:*** ☐ ***better*** ☐ ***worse*** ☐ ***staying the same***

Please describe activities or things that you cannot do because of your problem.

_____

_____

Please list all pelvic and abdominal surgeries with dates of operation.

_____

_____

Date of last pelvic examination: _____ *Date of last urinalysis:* _____

Special Tests Performed? _____ *Type:* _____ *Date:* _____

1. ***OCCURENCE OF INCONTINENCE OR LEAKAGE***
   ☐ Never ☐ Less than 1/month ☐ More than 1/month ☐ Less than 1/week ☐ More than 1/week ☐ Almost every day
   ☐ #_____leaks per day

2. ***PROTECTION WORN***
   ☐ No protection ☐ Pantishields ☐ Mini pad ☐ Maxi pad ☐ Diaper/Serenity

3. ***SEVERITY***
   ☐ No leakage ☐ Few drops ☐ Wet underwear ☐ Wet outerwear

4. ***POSITION OR ACTIVITY WITH LEAKAGE***
   ☐ Lying down ☐ Sitting ☐ Standing ☐ Changing positions (from sit to stand) ☐ Sexual activity ☐ Strong urge

5. ***HOW LONG CAN YOU DELAY THE NEED TO URINATE?***
   ☐ Indefinitely ☐ 1+ hours ☐ ½ hours ☐ 15 minutes ☐ Less than 10 minutes ☐ 1-2 minutes ☐ not at all

6. ***ACTIVITY THAT CAUSES URINE LOSS***
   ☐ Vigorous activity ☐ Moderate activity ☐ Light activity ☐ No activity ☐ Type_____

7. ***PROLAPSE (falling out feeling)***
   ☐ Never ☐ Occasionally/with menses ☐ Pressure at the end of the day ☐ Pressure with standing ☐ Perineal pressure all day

8. ***FREQUENCY OF URINATION (Daytime)***
   ☐ 0 times per day ☐ 1 – 4 times ☐ 5 – 8 times ☐ 9 – 12 times ☐ 13+ times

9. ***FREQUENCY OF URINATION (Nighttime)***

☐ 0 times per night ☐ 1 time per night ☐ 2 times per night ☐ 3 times per night ☐ 4 times per night

10. ***FLUID INTAKE (Includes water and beverages)***

☐ 9+ 8 oz glasses per day ☐ 6-8 8 oz glasses per day ☐ 3-5 8 oz glasses per day ☐ 1-2 8 oz glasses per day

How many caffeinated glasses? _____

11. ***FREQUENCY OF BOWEL MOVEMENTS***

☐ 2 times per day ☐ 1 time per day ☐ every other day ☐ once every 4-7 days ☐ weekly ☐ other _____

12. ***AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?***

☐ Can stop completely ☐ Can maintain a deflection of the stream ☐ Can partially deflect the urine stream

☐ Unable to deflect or slow the stream

13. ***DO YOU HAVE TROUBLE INITIATING A URINE STREAM?***

☐ Never ☐ More than 1/month ☐ Less than 1/week ☐ Almost every day

14. ***ATTITUDE TOWARDS PROBLEM***

☐ No problem ☐ Minor inconvenience ☐ Slight problem ☐ Moderate problem ☐ Major problem

15. ***CONFIDENCE IN CONTROLLING YOUR PROBLEM***

☐ Complete confidence ☐ Moderate confidence ☐ Little confidence ☐ No confidence

16. ***Are you sexually active?*** ***Are you pregnant or attempting pregnancy?***

☐ Yes ☐ No ☐ Yes ☐ No

Number of pregnancies?_____ Complications? _____

Males: Sexual problems after surgery _____

17. ***History of or present sexually transmitted diseases? Type:*** _____

18. ***Pain or problems with sexual activity or urination? Describe:***_____

_____

19. ***Have you ever been taught how to do pelvic floor or Kegel exercises?***

☐ Yes ☐ No When?_____ By whom? _____

20. ***How often do you do pelvic floor exercises?*** _____

21. ***Any comments or concerns not asked?***_____

_____

_____