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?***_____

_____

_____