VANITA'S REHAB
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PELVIC FLOOR QUESTIONNAIRE

Name _____ Date_____ Date of Birth _____

Please describe your mainproblem:_____
_____

When did it begin? _____; is the onset associated with one particular event?
If so, what was the event _____; is it getting: ❑ better ❑ worse or ❑ staying the same

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

Are you on Hormone Replacement Therapy? ❑ Yes ❑ No If yes, please specify _____
Are you using a vaginal cream? ❑ Yes ❑ No If yes, please specify _____

SOCIAL HISTORY:
Marital Status _____ Ages of children living at home _____
Education level _____

Please briefly describe any difficulty moving around (limitations in walking, balance, getting out of a chair, etc.)
_____
_____
_____

What are your hobbies? _____

PLEASE COMPLETE THE FOLLOWING AS COMPLETELY AS POSSIBLY. YOUR THERAPIST WILL DISCUSS THIS INFORMATION WITH YOU.

OBSTETRICAL/GYNECOLOGICAL HISTORY:
# of pregnancies _____ # of vaginal deliveries _____ # C-Sections _____
Birth weight of babies _____ _____ _____ _____ # of episiotomies _____
Did you have a painful episiotomy scar? ❑ Yes ❑ No
Length of labor? _____

Do you have pain with: ❑ Sexual intercourse ❑ Pelvic exam ❑ Examination with speculum
❑ Menses ❑ Tampon insertion
Pelvic Pain:
Location of pain _____
What makes your pain better? _____
What makes your pain worse? _____

Are you having regular periods? ❑ Yes ❑ No At what age did you start periods? _____
When was your Menopause onset? _____ At what age did your periods become regular? _____

Date of last pelvic examination _____

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Have you ever been taught how to do pelvic floor or Kegel exercises? ❑ Yes ❑ No
When? _____ By whom? _____
How often do you do pelvic floor exercises? _____

UROLOGICAL HISTORY:
Date of last urinalysis _____
Special Tests Performed? _____ Type _____ Date _____
Do you have a history or urinary tract infections? ❑ Yes ❑ No If yes, when was your last infection? _____

Do you have a history of urine loss as a child? ❑ Yes ❑ No
as an adolescent? ❑ Yes ❑ No
after childbirth? ❑ Yes ❑ No

Have you had: urethral dilations? ❑ Yes ❑ No If yes, specify reason: _____
urodynamic tests? ❑ Yes ❑ No If yes, specify reason: _____
recent catheter use? ❑ Yes ❑ No If yes, specify reason: _____
cystoscopes? ❑ Yes ❑ No If yes, specify reason: _____
Previous treatment for incontinence? ❑ Yes ❑ No ___exercises ___medication ___surgery

DO YOU EXPERIENCE A LOSS OF URINE: (*check yes or no*)
With cough, laugh, sneeze? ❑ Yes ❑ No
When lifting objects? ❑ Yes ❑ No
With exercise? ❑ Yes ❑ No
When you have a strong urge to urinate? ❑ Yes ❑ No
On your way to the bathroom? ❑ Yes ❑ No
Just as you get to the toilet/remove clothing? ❑ Yes ❑ No
Other episodes of incontinence? ❑ Yes ❑ No

DO YOU: (*check yes or no*)
Experience an urge to urinate when you hear running water? ❑ Yes ❑ No
Have pain with urination? ❑ Yes ❑ No
Have burning with urination? ❑ Yes ❑ No
Have blood in your urine? ❑ Yes ❑ No
Have to strain to empty your bladder? ❑ Yes ❑ No
Dribble after you empty your bladder? ❑ Yes ❑ No
Do you feel you still have urine in your bladder after urinating? ❑ Yes ❑ No

ABSORBENT PRODUCTS USED: (*indicate # used per day*)
Pantyliner/pantyshield _____
Menstrual pads (mini, maxi) _____
Incontinence pad (poise, depends) _____
Incontinence brief _____
# of underwear changes _____
Do you soak the pad fully? ❑ Yes ❑ No
Do you change the pad each time it is wet? ❑ Yes ❑ No

OCCURRENCE OF INCONTINENCE OF LEAKAGE
❑ Never
❑ Less than 1/month
❑ More than 1/month
❑ Less than 1/week
❑ More than 1/week
❑ Almost every day
❑ More than 1/day # ___

SEVERITY
❑ No leakage
❑ Few drops
❑ Wet underwear
❑ Wet outerwear

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POSITION OR ACTIVITY WITH LEAKAGE

- ❑ Lying down
- ❑ Sitting
- ❑ Standing
- ❑ Changing positions (from sit to stand)
- ❑ Intercourse
- ❑ Strong Urge

HOW LONG CAN YOU DELAY THE NEED TO URINATE?

- ❑ Indefinitely
- ❑ 1+ hours
- ❑ ½ hour
- ❑ 15 minutes
- ❑ Less than 10 minutes
- ❑ 1-2 minutes
- ❑ Not at all

ACTIVITY THAT CAUSES URINE LOSS

- ❑ Vigorous activity
- ❑ Moderate activity
- ❑ Light activity
- ❑ No activity

PROLAPSE (Falling out Feeling)

- ❑ Never
- ❑ Occasionally/with menses
- ❑ Pressure at the end of the day
- ❑ Pressure with straining
- ❑ Pressure with standing
- ❑ Perineal pressure all day

When does it occur? _____

FREQUENCY OF URINATION (DAYTIME)

- ❑ 0 Times Per Day
- ❑ 1-4
- ❑ 5-8
- ❑ 9-12
- ❑ 13+

FREQUENCY OF URINATION (NIGHTTIME)

- ❑ 0 Times Per Night
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4+

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

DO YOU HAVE TROUBLE INITIATING A URINE STREAM?

- ❑ Never
- ❑ More than 1/month
- ❑ Less than 1/week
- ❑ Almost every day

ATTITUDE TOWARDS PROBLEM

- ❑ No problem
- ❑ Minor inconvenience
- ❑ Slight problem
- ❑ Moderate problem
- ❑ Major problem

CONFIDENCE IN CONTROLLING YOUR PROBLEM

- ❑ Complete confidence
- ❑ Moderate confidence
- ❑ Little confidence
- ❑ No confidence

FUNCTIONAL LIMITATIONS: (*check yes or no*)

Do you have difficulty:

Getting on/off the toilet?	❑ Yes	❑ No
Getting clothes on/off?	❑ Yes	❑ No
With toilet hygiene?	❑ Yes	❑ No
Getting out of bed?	❑ Yes	❑ No

DAILY FLUID INTAKE:

Do you restrict fluids because of your incontinence? ❑ Yes ❑ No

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Have you restricted your physical activities because of incontinence/pain?(exercise, walking, dancing, etc.) ❑ Yes ❑ No

If yes, please give specific examples _____

_____

_____

Have you restricted your social activities because of incontinence/pain? (Have to stay close to a bathroom, interrupted activities due to needing to go to the bathroom often, etc.) ❑ Yes ❑ No

If yes, please give specific examples _____

_____

_____

Have you had changes in intimate relationship/sexual functioning due to incontinence/pain? ❑ Yes ❑ No

If yes, please give specific examples _____

_____

_____

Please circle the number on the scale below which best indicates the extent to which **incontinence** limits your daily life:

1 2 3 4 5 6 7 8 9 10

No limits Severely Limiting

Please circle the number on the scale below which best indicates the extent to which **pain** limits your daily life:

1 2 3 4 5 6 7 8 9 10

No limits Severely Limiting

Any comments or concerns not asked? _____

_____

_____

_____

_____

_____

_____

_____

_____