

VANITA'S  REHAB

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MALE PELVIC FLOOR QUESTIONNAIRE

Name _____ Date _____ Date of Birth _____

Please describe your main problem: _____

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 _____

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.

PELVIC PAIN:

Location of pain _____
 What makes your pain better? _____
 What makes your pain worse? _____

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

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: _____
 prostate enlargement Yes No If yes, specify reason: _____
 prostate surgery Yes No If yes, specify reason: _____

Date of last pelvic examination _____

Previous treatment for incontinence? Yes No ___exercises ___medication ___surgery

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? _____

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*)

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

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

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

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+

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

BOWEL HABITS:

- How often do you have a bowel movement? _____
- Do you strain having a bowel movement? Yes No
- Do you experience abdominal cramping? Yes No
- Do you leak/stain feces? Yes No If yes, how often? _____
- Do you experience diarrhea? Yes No If yes, How often? _____
- Do you use laxatives? Yes No If yes, how often/week? _____
- Do you use enemas? Yes No If yes, how often/week? _____
- Do you include fiber in your diet daily? Yes No If yes, how much? _____

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

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 _____
