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MALE PELVIC DYSFUNCTION QUESTIONAIRE

Do you now have or have you had a history of the following? Explain 'yes' responses & include dates.

Y/N Abdominal pain
Y/N Joint problems
Y/N Allergies
Y/N Low back /sciatica
Y/N Bladder cancer
Y/N Pelvic pain
Y/N Bladder infections
Y/N Pelvic trauma
Y/N Blood in urine
Y/N Sensitivity to latex
Y/N Broken bones
Y/N Sexual/ physical abuse
Y/N Other (please list)_____

Y/N Childhood bladder problems
Y/N Sexually transmitted disease
Y/N Constant dribbling of urine
Y/N TMJ
Y/N Constipation
Y/N Trouble emptying bladder
Y/N Fecal incontinence
Y/N Trouble feeling bladder fullness
Y/N Fibromyalgia
Y/N Trouble holding back gas
Y/N Irritable Bowel Syndrome
Y/N Trouble initiating urine stream

Explain "yes" responses:_____
_____

Surgical History:

Y/N Surgery for your back/spine
Y/N Surgery for bladder
Y/N Surgery for brain
Y/N Surgery for your prostate
Y/N Surgery for your abdominal organs

Other type please describe:_____

Explain "yes" responses:_____
_____

Diagnosis specific to current problem not already indicated:_____
_____

Medications: **Start Date:** **Reason for taking:**

_____
_____
_____
_____
_____
_____

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Bladder Habits

1. Are you unable to stop the flow of urine when on the toilet? **Y/N**
2. Is it difficult to tell when you need to go to the toilet? **Y/N**
3. Do you strain to pass urine? **Y/N**
4. Do you empty your bladder before you experience the urge to urinate? **Y/N**
5. Do you have difficulty completely emptying your bladder? **Y/N**
6. Do you have difficulty initiating the stream of urine? **Y/N**
7. Do you have triggers that make you feel you cannot wait to use the toilet? **Y/N**
8. Do you have pain or burning with urination? **Y/N**
9. Do you have pain or discomfort when you wipe yourself? **Y/N**
10. Do you leak more during, before or after your period? **Y/N**

Bowel Habits

1. Are you unable to feel that you need to have a bowel movement or pass gas? **Y/N**
2. Do you strain to have a bowel movement? **Y/N**
3. Do you feel your rectum is not completely empty after a bowel movement? **Y/N**
4. Do you have difficulty initiating a bowel movement? **Y/N**
5. Do you have pain or burning with bowel movements? **Y/N**
6. Do you have a history of hemorrhoids **Y/N**
7. Have you experienced a change in you bowel habits? **Y/N**
   If 'yes' please describe: _____
8. Do you take anything to help you pass stool? **Y/N**
   If 'yes' please list: _____
9. Do you have difficulty holding back gas? **Y/N**

Pelvic Floor Symptoms

1. Are you sexually active? **Y/N**
2. Do you have pain with intercourse or penetration? **Y/N**

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BLADDER AND BOWEL SYMPTOM QUESTIONNAIRE

1. **How often do you urinate during the day?** _____times, at night? _____ times.
2. **How often do you have a bowel movement**? _____times/ day/ week?
3. **How often do you experience bowel /bladder leakage?** (please circle all that apply)
   Never less than daily daily throughout the day nighttime/sleep
4. **What is the amount of leakage?** (please circle all that apply)
   No leakage soils pad or underwear soils outerwear
   How many do you use per day? _____
5. **What type of protection do you wear?** (please circle all that apply)
   None absorbant pads specialty product other
6. **What causes you to leak?** (please circle all that apply)
   Vigorous activity (running, aerobics)
   Light activity (walking, light house work)
   Cough/ sneeze
   Walking to the toilet
   Strong urge to go
   Intercourse or sexual activity
   Other _____
7. **How long can you delay the need to urinate?** (please circle all that apply)
   Not at all 1-5 min 5-10 min 10-30 min 30+min
8. **How much fluid do you drink each day** (one glass = 8 oz or one cup)
   _____ Total glasses of liquid per day
   _____ # of caffeinated glasses per day
   _____ # of alcoholic beverages per day
9. **Rate your feelings as to severity of this problem from 0- 10, 10 being the worst.**
   0_____10

Additional Comments:

_____
_____
_____
_____
_____
_____
_____

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CONSENT FOR EVALUATION AND TREATMENT

I understand that my physician has referred me to physical therapy for evaluation and treatment of pelvic floor dysfunction, and it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the rectum.

I understand that if I am uncomfortable with the assessment or treatment procedures at any time, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

I understand that I may refuse any part of the treatment plan that I am uncomfortable with.

I understand that at any time I may request to have another person present during the evaluation and treatment.

I hereby request and consent to the evaluation and treatment to be provided by the physical therapist.

Patient Signature: _____

Patient Name (please print): _____

Signature of Parent or Guardian (if applicable): _____

****** If you are post surgery, have severe pelvic pain, sensitivity to KY jelly, creams or latex, please inform the therapist prior to pelvic floor assessment.***