

FEMALE PELVIC DYSFUNCTION QUESTIONNAIRE

Name: _____ Date: _____

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

- | | |
|-----------------------------------|---|
| Y/N Abdominal pain | Y/N Childhood bladder problems |
| Y/N Joint problems | Y/N Sexually transmitted disease |
| Y/N Allergies | Y/N Constant dribbling of urine |
| Y/N Low back /sciatica | Y/N TMJ |
| Y/N Bladder cancer | Y/N Constipation |
| Y/N Pelvic pain | Y/N Trouble emptying bladder |
| Y/N Bladder infections | Y/N Fecal incontinence |
| Y/N Pelvic trauma | Y/N Trouble feeling bladder fullness |
| Y/N Blood in urine | Y/N Fibromyalgia |
| Y/N Sensitivity to latex | Y/N Trouble holding back gas |
| Y/N Broken bones | Y/N Irritable Bowel Syndrome |
| Y/N Sexual/ physical abuse | Y/N Trouble initiating urine stream |

Y/N Other (please list) _____

Explain 'yes' responses: _____

Surgical History:

- | | |
|---|---|
| Y/N Surgery for your back/spine | Y/N Surgery for your brain |
| Y/N Surgery for bladder | Y/N Surgery for abdominal organs |
| Y/N Other type please describe _____ | Y/N Surgery for your female organs |

OG/GYN History: Explain 'yes' responses and include dates.

- | | |
|---------------------------------------|---|
| Y/N Painful periods | Y/N Episiotomy/ Tears # _____ |
| Y/N Fibroids | Y/N Pelvic inflammatory disease |
| Y/N Painful penetration | Y/N Difficult childbirth |
| Y/N D&C procedure | Y/N Unusual discharge |
| Y/N Pregnancies # _____ | Y/N Uterine/rectal/bladder prolapsed |
| Y/N Endometriosis | Y/N Perimenopause |
| Y/N Vaginal deliveries # _____ | Y/N Prolapse or falling out feeling |
| Y/N Cysts | Y/N Menopause (date of last period) |
| Y/N C-section # _____ | |
| Y/N Vaginal Dryness | |

Explain 'yes' responses: _____

Diagnosis specific to current problem not already indicated: _____

Medications: _____ **Start date:** _____ **Reason for taking:** _____

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

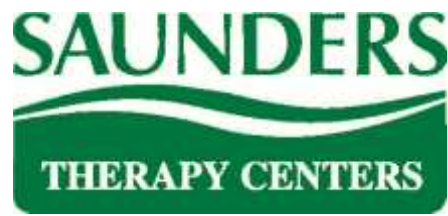
1. Are you sexually active? Y/N
2. Do you have pain with intercourse or penetration? Y/N
3. Do you have pain with use of tampons? Y/N

BLADDER AND BOWEL SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

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 pantiliner maxi pad 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: _____



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 vagina and/ or 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 Name (please print): _____

Patient Signature: _____

Signature of Parent or Guardian (if applicable): _____

**** If you are pregnant, have infections of any kind, have vaginal dryness, are less than 6 weeks post partum or post surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.*