

MALE PELVIC DYSFUNCTION QUESTIONNAIRE

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

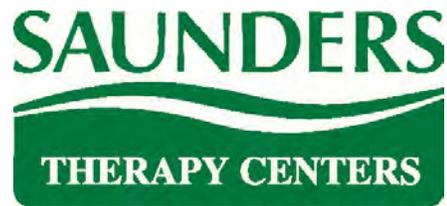
- Y/N Surgery for brain
Y/N Surgery for your prostate
Y/N Surgery for your abdominal organs

Other type please describe:

Explain "yes" responses:

Diagnosis specific to current problem not already indicated:

Table with 3 columns: Medications, Start Date, Reason for taking.



**Bladder Habits**

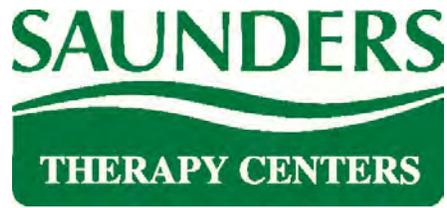
1. Are you unable to stop the flow of urine when on the toilet? Y/N
2. Is it difficult to tell when you need to go to the toilet? Y/N
3. Do you strain to pass urine? Y/N
4. Do you empty your bladder before you experience the urge to urinate? Y/N
5. Do you have difficulty completely emptying your bladder? 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

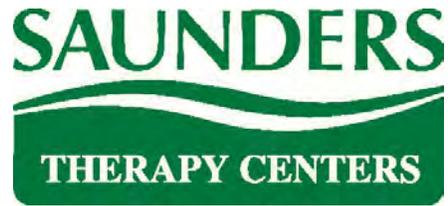


BLADDER AND BOWEL SYMPTOM QUESTIONNAIRE

- 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)
4. What is the amount of leakage? (please circle all that apply)
5. What type of protection do you wear? (please circle all that apply)
6. What causes you to leak? (please circle all that apply)
7. How long can you delay the need to urinate? (please circle all that apply)
8. How much fluid do you drink each day (one glass = 8 oz or one cup)
9. Rate your feelings as to severity of this problem from 0- 10, 10 being the worst.

Additional Comments:

Horizontal lines for writing 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 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.***