Hendricks Regional Health

Patient Questionnaire – Pelvic Floor

Please complete ***all pages*** of the following questionnaire, as this will assist your therapist in evaluating you. Should you need assistance, please ask the office staff. If you do not fill out this questionnaire, the therapist will have to spend your evaluation time completing it with you.
Thank you!

Name _____ Date _____

1. Please describe your main problem:
   _____
   _____

2. When did it begin (please use specific date: month, day, year)? _____
   _____

3. What symptoms did you first notice: _____

4. What activities or positions increase your complaints?
   _____
   _____

5. What activities or positions decrease your complaints? _____
   _____
   _____

6. Are your complaints getting: ☐ Better ☐ Worse ☐ Staying the same?
   _____

7. Have you had this problem before? ☐ NO ☐ YES, please explain: _____
   _____

8. **Medical History (check all that apply)** **Associated medications**

☐ heart disease	_____
☐ high blood pressure	_____
☐ lung/breathing problems	_____
☐ arthritis	_____
☐ pelvic pain	_____
☐ diabetes	_____
☐ stroke	_____
☐ other: _____	_____

9. Past History of **Injuries/Accidents**:

Year	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past **Surgical History**:

Year	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
History reviewed by Therapist **Date**

10. Occupation:

What does your job involve:

_____% Sitting; check all that apply: computer ☐, assembly line ☐, desk work ☐
_____% Driving; type of vehicle: _____
_____% Standing; surface: _____
_____% Lifting; range of weight lifted: _____
Number of times per hour: _____
From _____ to _____ (heights)
_____% Other: _____

11. Gynecological History:

	Date of Birth	Delivery Type	Length of Pushing	Complications
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

12. Do you have a painful episiotomy scar? Y ☐ N ☐
13. Do you have a history of urinary track infections? Y ☐ N ☐
14. Do you have a history of urine loss as a child? Y ☐ N ☐
15. Do you have a history of urine loss as an adolescent? Y ☐ N ☐
16. Do you have a history of urine loss after childbirth? Y ☐ N ☐

_____
_____

17. Date of last pelvic exam: _____ Last urinalysis: _____

Findings : _____

18. Have you ever had any special tests performed? Y ☐ N ☐

If yes, specify type and date _____
_____

19. When was your menopause onset, if applicable? _____

20. Have you been on hormone replacement therapy? Y ☐ N ☐

What type (pills, patch, cream) _____

21. Have you had any previous treatments for urinary incontinence:
exercises, medications, surgical procedures, other: Y ☐ N ☐

Explain: _____

22. Do you experience a loss of urine:

with coughing, laughing, sneezing? Y ☐ N ☐
when lifting objects? Y ☐ N ☐
with exercise, running, etc? Y ☐ N ☐
when you have a strong urge to urinate? Y ☐ N ☐
on the way to the bathroom? Y ☐ N ☐
just as you are getting to the toilet/removing clothes? Y ☐ N ☐

23. Do you experience an urge to urinate when you hear running water? Y ☐ N ☐

have difficulty initiating a urine stream?	Y ☐	N ☐
have difficulty stopping your stream?	Y ☐	N ☐
have pain with urination?	Y ☐	N ☐
have burning with urination?	Y ☐	N ☐
have blood in your urine?	Y ☐	N ☐
have to strain to empty your bladder?	Y ☐	N ☐
dribble urine when urinating?	Y ☐	N ☐
dribble after you empty your bladder?	Y ☐	N ☐
have painful intercourse?	Y ☐	N ☐

24. Voiding frequency: # of times/day _____ # of times/night _____?

25. Incontinence: # episodes/day _____# episodes/night _____?

26. Amount of urine loss: ☐ large ☐ moderate ☐ small ☐ few drops

27. Protective Devices: What type of protective device to you use? (Check all that apply):
☐ pantyliner ☐ maxipad ☐ minipad ☐diaper/serenity

28. How many of the above do you use per day? _____ per night?_____

29. Do you soak the pad fully? Y ☐ N ☐

30. Fluid Intake: # cups fluid/day? _____ How many are caffeinated? _____

31. Do you restrict fluid because of your incontinence? Y ☐ N ☐

32. How often do you have a bowel movement? _____

33. Are you ever constipated? Y ☐ N ☐ How do you resolve this?
_____

34. Do you experience diarrhea? Y ☐ N ☐

35. Do you use laxatives? Y ☐ N ☐

36. Do you use enemas? Y ☐ N ☐

37. Do you use fiber? Y ☐ N ☐

38. Are you sexually active? Y ☐ N ☐

39. Are you pregnant or attempting pregnancy? Y ☐ N ☐

40. Have you had any changes in your intimate relationships/
sexual functioning due to urinary incontinence? Y ☐ N ☐
If yes, explain: _____

41. Are you involved in any recreational activities? Y ☐ N ☐
If yes, what kind? _____

42. Are those activities restricted due to urinary incontinence? Y ☐ N ☐

43. Have you ever been taught how to do pelvic floor or Kegel exercises Y ☐ N ☐

When? _____ By whom? _____

44. What are your feelings about your problem on a scale of 1 to 10?

No impairment Severe impairment
0--------1--------2--------3--------4-------5-------6-------7-------8-------9--------10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

45. Please list any allergies (including allergy to Latex): _____
_____

46. Have you ever reacted to the following when handling, or after eating, avocados, bananas, tropical fruit, pineapple, kiwi, nectarines, peaches, cherries, chestnuts, poinsettia plants, balloons, elastic bandages or rubber products? ☐ YES ☐ NO

47. Why did you choose this facility for your service? (Check all that apply)

☐ Reputation of Clinic ☐ Insurance Requirement ☐ My physician/s recommendation
☐ Location ☐ Friend's or family's recommendation
☐ Other: _____

48. I desire to learn: (Check all that apply)

☐ exercises ☐ proper nutrition ☐ proper voiding habits
☐ posture correction ☐ additional resources that may help me

49. I prefer to learn in the following ways:

☐ demonstration ☐ verbal instruction ☐ video ☐ written material

50. Difficulty with writing? ☐ YES, related to this problem ☐ YES, unrelated to this problem
☐ NO ☐ comment _____

Difficulty with reading? ☐ YES ☐ NO ☐ comment _____

51. My primary language is: ☐ English ☐ Spanish ☐ other

52. Check current or prior conditions that you may have or had:

☐ language impairment ☐ emotional disorder ☐ mental disorder; type _____
☐ vision impairment ☐ cognitive disorder ☐ communicative disorder
☐ hearing impairment ☐ physical impairment ☐ developmental disabilities

Comments: _____

53. When is your next doctor's appointment for this problem? _____

54. Did your doctor give you any limitations regarding this problem?

If yes, please list/explain: _____

55. Any comments or concerns not asked? _____
_____

Please indicate with a "P" where your present pain level is (if applicable) ☐ N/A
(0 = no pain, 10 = worst ever imaginable/emergency room pain):

0	1	2	3	4	5	6	7	8	9	10

Functional Limitations: What are you **limited in doing** (your current problems stops you from functioning as you previously did) or **unable to do** (you avoid doing and/or can no longer do) because of your **current problem that you are receiving therapy for**? This refers to any **new** limitations from this **current problem** or **recent flare up**. Please complete (report in minutes, hours, distance, etc.) **for activities limited at this time**. If you had any limitations **before** this problem/episode, please list in space at bottom of this question.

Functional Limitations: (Check those that apply)

☐ 1. Incontinence and/or pelvic pain has limited my ability to be involved in recreational activities.
If yes, please specify. _____
☐ 2. Pelvic pain has altered my sexual lifestyle. Explain: _____
☐ 3. Pelvic pain has limited my ability to perform activities of daily living such as:
_____
☐ 4. Loss of urine is experienced with the following activities: _____
☐ 5. Loss of urine is experienced during the night: frequency: _____
☐ 6. I can delay the need to urinate _____ minutes/hours.
☐ 7. I avoid activities due to incontinence and/or pelvic pain:
☐ _____
☐ 8. _____
☐ 9. _____
☐10. _____

Limitations Prior to this problem:

_____
_____
_____

Therapist Use Only:
_____
_____
_____
_____
_____
_____
_____
_____
_____

History Reviewed by Therapist_____ Date_____