FYZICAL®
Therapy & Balance Centers

PELVIC FLOOR QUESTIONAIRE

Patient Information

Last Name: _____First Name: _____Middle Initial:_____

Physician: _____Date:_____

Please describe your main problem _____

_____

When did it begin? _____ Is it getting: better, worse, or staying the same (circle one)

Please describe activities or things that you cannot do because of your problem.

_____

_____

Please list all pelvic and abdominal surgeries with dates of operation.

_____

_____

Date of last pelvic examination _____ Date of last urinalysis _____

Special Tests Performed? _____ Type _____ Date _____

1. OCCURRENCE OF INCONTINENCE OR LEAKAGE
   ___Never ___Less than 1/month ___More than 1/month ___Less than 1/week
   ___More than 1/week ___Almost every day # _____ leaks per day

2. PROTECTION USED
   ___No Protection ___Pantishields ___Mini Pad ___Maxi Pad
   Bladder control pad type _____

3. SEVERITY
   ___No leakage ___Few drops ___Wet underwear ___Wet outerwear

4. POSITION OR ACTIVITY WITH LEAKAGE

___Lying down ___Sitting ___Standing ___Changing positions (sit to stand)
___Sexual activity ___Strong Urge

5. HOW LONG CAN YOU DELAY THE NEED TO URINATE?

___Indefinitely ___1+ hours ___1/2 hour ___15 minutes ___Less than 10 minutes
___1-2 minutes ___Not at all

6. ACTIVITY THAT CAUSES URINE LOSS

___Vigorous activity ___Moderate activity ___Light activity
___No activity Type _____

7. PROLAPSE

___Never ___Occasionally/ with menses ___Pressure at the end of the day
___Pressure with staining

8. FREQUENCY OF URINATION (DAYTIME)

___ 0 times per day ___ 1-4 ___ 5-8 ___ 9-12 ___ 13+

9. FREQUENCY OF URINATION (NIGHTTIME)

___ 0 times per night ___ 1 ___ 2 ___ 3 ___ 4+

10. FLUID INTAKE

___Includes water and beverages ___ 9+ 8oz glasses per day ___ 6-8 8oz per day
___ 3-5 8 oz per day ___ 1-2 8oz per day ___ How many caffeinated glasses? _____

11. FREQUENCY OF BOWEL MOVEMENTS

___ 2 times per day ___ 1 time per day ___ Every other day ___ Once every 4-7 day
___ Weekly

12. 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

13. DO YOU HAVE TROUBLE INITIATING A URINE STREAM?

___ Never ___ More than 1/month ___ Less than 1/week ___ Almost every day

14. ATTITUDE TOWARDS PROBLEM

___ No Problem ___ Minor Inconvenience ___ Slight problem ___ Moderate Problem
___ Major Problem

15. CONFIDENCE IN CONTROLLING YOUR PROBLEM

___ Complete confidence ___ Moderate confidence ___ Little confidence
___No confidence

16. Are you sexually active? Yes _____ No _____

Are you pregnant or attempting pregnancy? Yes _____ No _____

Number of pregnancies? _____

Complications? _____

_____

17. History of or present sexually transmitted diseases? Type _____

_____

18. Do you have pain or problems with sexual activity or urination? Yes _____ No _____

Describe: _____

_____

19. Have you ever been taught or prescribed to do pelvic floor/Kegel exercises?
Yes _____ No _____ When? _____ By Whom? _____

20. How often do you do pelvic floor exercises? _____

Any comments or concerns nor asked? _____

_____

_____