Name_____**(DOB)**_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Do you ever leak during or after sexual intercourse	Y/N	Kidney Infections
Y/N	Bladder leakage during cough/sneeze/laugh/jump		
Y/N	Other/describe _____		

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ___small ___ medium___ large.
4. Frequency of bowel movements _____times per day, _____times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
   _____minutes, _____hours, _____not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?_____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. What form of protection do you wear? (Please complete only one)

___None
___Minimal protection (Tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxipad)
___Maximum protection (Specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

Name_____(DOB)_____

Additional Pelvic Health Questions:

Are you sexually active? Yes_____ No_____

Do you have a history of, or present, sexually transmitted disease? Yes_____ No_____
If yes, please explain:
_____

Do you experience pain or other problems with sexual activity? Yes _____ No _____
If yes, please describe:
_____
_____

Have you ever been taught how to do pelvic floor or Kegel exercises? Yes_____ No_____
If yes, When?_____ By whom?_____ How often do you do them?_____

Any comments or concerns not addressed in this questionnaire?
_____
_____

Questions for female patients only:
Gynecological History:
Have you ever been diagnosed with:

Y/N Pelvic Organ Prolapse	Y/N Endometriosis	Y/N Pelvic pain
Y/N Cysts	Y/N Urinary Tract Infections	Y/N Interstitial Cystitis (IC)
Y/N Pelvic Inflammation Disease	Y/N Fibroids	Y/N Fistual
Y/N Polycystic Ovarian Syndrome (PCOS)	Y/N Lichen Sclerosus or Lichen Planus	

Have your menstrual periods stopped? Yes / No Date of last period: _____
Do/did you have pain with your menstrual periods? Yes / No
Are you on hormone replacement/blocking therapy? Yes / No
If yes, which one(s):
_____

Other issues not listed? _____

Are you pregnant? Yes_____ No_____ Attempting to get pregnant? Yes____No_____

Questions for Male patients only:
Have you ever experience or been diagnosed with:

Y/N Prostatitis	Y/N Lichen Sclerosus or Licens Planus	Y/N Peyronies Disease
Y/N Erectile dysfunction	Y/N Testicular/Scrotal pain	Y/N Pelvic Pain
Y/N Pelvic Pain	Y/N Fistula	Y/N Painful ejaculation
Y/N Low Testosterone		

Are you on hormone replacement/blocking therapy? Yes/No
If yes, which one(s):
_____

Other issues not listed? _____