PELVIC FLOOR SCREENING QUESTIONNAIRE

Name:_____ DOB: _____

Date:_____ Date of last doctor visit:_____

Last pelvic exam: _____ Last urinalysis: _____

Occupation/Activities: _____

What problem brings you here? _____

_____

When did it start? _____

What aggravates/makes it worse? _____

What makes your symptoms better? _____

Do you have pain? ☐yes ☐no If yes, rate your pain 0 – 10 (10 = worst) _____

Describe your pain: ☐achy ☐pressure ☐falling out feeling ☐sharp ☐ burning

_____

What makes your pain worse? _____

What makes your pain better? _____

Are any activities difficult due to this problem? ☐ yes ☐ no

If yes, what activities _____

Medical History - please check if you now have or have had a history of:

☐ pacemaker/defibrillator	☐ surgically implanted device/metal	☐ cancer
☐ diabetes	☐ hypertension/hypotension	☐ cardiovascular
☐ hormone replacement	☐ osteoporosis/osteopenia	☐ multiple sclerosis
☐ joint pain/problems	☐ sexually transmitted disease	☐ HIV/AIDS
☐ pregnant	☐ emphysema/bronchitis/respiratory	☐ stroke
☐ anxiety/depression	☐ other psychological problems	☐ sexual abuse
☐ recent bowel/bladder changes	☐ unexplained weight loss	☐ night pain
☐ fever/sweats/chills	☐ recent or major surgery	☐ cholesterol

Please explain boxes checked: _____

_____

List any surgeries:_____

_____

List any tests:_____

_____

Allergies: _____

Medications: _____

_____

_____

Therapist Signature/Date

Heartland Women's Healthcare

PELVIC FLOOR QUESTIONNAIRE – page 2

Name: _____

Urogynecological History: please check if applicable:

☐ bladder or urinary tract infections ☐ constipation ☐ fecal incontinence
☐ trouble holding back gas ☐dribbling immediately post urination
☐ constant dribbling of urine ☐ trouble initiating urine stream ☐ vaginal dryness/itching
☐ weak/slow urine stream ☐ pain during urination ☐ blood in urine
☐ abnormal color of urine ☐abnormal odor of urine ☐ painful periods
☐ painful intercourse ☐ menopause or date of last period _____

How often do you urinate during the day?

☐ every 4 hours ☐ every 2 hours ☐ every hour ☐ every 30 – 59 minutes

How often do you get up to urinate at night?

☐ rarely/never ☐ one time/night ☐ 2 to 3 times/night ☐ 3+ times/night

Do you leak at night?

☐ rarely/never ☐ 1-2 times/week ☐ 3-4 times/week ☐ 4+ times/week

How often do you leak during the day?

☐ once every 2 weeks ☐once a week ☐ 2-3 days/week ☐ 4 or more days/week
☐ once a day ☐ multiple times daily ☐ constantly all day

How large are your leaks?

☐ a few drops ☐ a small gush or spurt ☐ a large leak ☐ varies

What type of protection do you use and how many/day? _____

What activities cause you to leak?

☐ coughing/sneezing ☐ walking ☐ laughing ☐ position change ☐ bending/lifting
☐ running/jumping ☐ aerobics ☐ feeling cold ☐ water running/shower
☐ during intercourse ☐ before/during menstruation ☐ key in the door
☐ being constipated ☐ _____

Fluid intake:

Caffeine:_____ ounces/day Alcohol: _____ drinks/day
Water: _____ounces/day Other:_____ounces/day

Childbirth history:

_____# of vaginal deliveries _____# of episiotomies _____# of Cesarean deliveries
Year/weight of children: _____
☐ leaking during pregnancy or postpartum Are you pregnant? ☐ Yes ☐ No
Any complications? _____

Have you been instructed before to perform pelvic floor or Kegel strengthening exercises?

_____

What are your goals related to this physical therapy? _____

_____

Patient Signature/Date: _____

Therapist Signature: _____ **Date:** _____ **Time:** _____

	Contact Physician if :
Blood Pressure_____	>160/90 or < 90/50
Resting Pulse Rate_____	> 100 or < 60 bpm
O2 Sats_____	< 90%