Pelvic Floor Therapy Questionnaire

Patient Name_____ **Date**_____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____ Number of vaginal deliveries _____

Birth weight of largest baby _____ Number of cesarean deliveries_____

Number of episiotomies _____ Date of last pap smear _____

Did you have any trouble healing after delivery? ..... Yes ☐ No ☐

Did you have a history of sexual abuse or trauma? ..... Yes ☐ No ☐

Are you having regular periods/menstrual cycles? ..... Yes ☐ No ☐

Do you have frequent urinary tract infections? ..... Yes ☐ No ☐

Pain

Do you have pain with sexual intercourse? ..... Yes ☐ No ☐

Do you have pain with a pelvic exam? ..... Yes ☐ No ☐

Do you have pain with tampon use? ..... Yes ☐ No ☐

Do you back, leg, groin or abdominal pain? ..... Yes ☐ No ☐

Test Results

Urodynamics test ..... Yes ☐ No ☐ Results _____

Cytoscope ..... Yes ☐ No ☐ Results _____

Urine test ..... Yes ☐ No ☐ Results _____

Bowel test ..... Yes ☐ No ☐ Results _____

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Pelvic Floor Therapy Questionnaire (continued)

Bladder Symptoms

Do you lose urine when you:

Cough/sneeze/laugh? ..... Yes ☐ No ☐

Lift/exercise/jump? ..... Yes ☐ No ☐

On the way to the bathroom? ..... Yes ☐ No ☐

Have a strong urge to urinate? ..... Yes ☐ No ☐

Hear running water? ..... Yes ☐ No ☐

Other _____

Do you wet the bed? ..... Yes ☐ No ☐

Do you have burning/pain with urination? ..... Yes ☐ No ☐

Do you have difficulty starting a stream of urine? ..... Yes ☐ No ☐

Do you strain to empty your bladder? ..... Yes ☐ No ☐

Do you feel unable to empty your bladder fully? ..... Yes ☐ No ☐

Do you experience a sensation of 'falling out' or heaviness? ..... Yes ☐ No ☐

Do you have pain with a full bladder? ..... Yes ☐ No ☐

Do you experience an excessively strong urge to urinate? ..... Yes ☐ No ☐

Do you urinate more than 7 times a day? ..... Yes ☐ No ☐

Bowel Symptoms

Do you strain to have a bowel movement? ..... Yes ☐ No ☐

Do you leak/stain feces? ..... Yes ☐ No ☐

Do you include fiber in your diet? ..... Yes ☐ No ☐

Do you have diarrhea often? ..... Yes ☐ No ☐

Do you take laxatives/enema regularly? ..... Yes ☐ No ☐

Do you leak gas by accident? ..... Yes ☐ No ☐

Do you have pain with bowel movements? ..... Yes ☐ No ☐

Do you have a very strong urge to move your bowels? ..... Yes ☐ No ☐

How often do you move your bowels? _____ Per day ☐ Per week ☐

Stool consistency? Liquid ☐ Soft ☐ Firm ☐ Pellets ☐ Other _____

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