Women's Pelvic Health Questionnaire

Name: ______________________________ DOB: _____________

Primary Physician: ______________________________ Referring Physician: ____________________________

Describe the reason for today's appointment (main complaint/problem): ____________________________
____
____
____

What goals do you hope to accomplish with therapy? ____
____
____

When did the problem begin? _____________ Is it better, worse, or staying the same? __________________

Have you had any prior treatment for this problem? YES / NO If yes, please describe: ________________
____

List activities or things that you cannot do because of this problem. How does the problem affect your life? ____
____

What are you currently doing to manage the problem? ____
____

Medical History: *Please check any that you have had or currently have*

☐ Childhood illnesses	☐ Back problems	☐ Epilepsy	☐ Arthritis
☐ Heart problems	☐ High blood pressure	☐ Stroke	☐ Serious injury
☐ Lung disease	☐ Chronic cough	☐ Tuberculosis	☐ Car accident
☐ Kidney disease	☐ Diabetes	☐ Cancer	☐ Glaucoma
☐ Urinary Tract Infections	☐ Emotional problems	☐ Bowel problems	☐ Thyroid problems
☐ Liver disease	☐ Seizure disorder	☐ Psychiatric disorder	☐ Neurologic Disease

☐ Other (please specify): ____

Allergies: Do you have any allergies? YES / NO If yes, please list what you are allergic to and the reaction you have had: ____
____

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Medications: Please list all of your current medications (include dosage & frequency taken): ___________

____

____

____

Surgical History: Have you ever had any operations? YES / NO If yes, please list the TYPE of surgery, the REASON, and the DATE of surgery: ____

____

Health Habits:

Do you see a doctor regularly for exams? YES / NO

Do you exercise regularly? YES / NO If yes, what type of exercise & how often? _______________________

____

Do you have any physical limitations? YES / NO If yes, please explain: _______________________________

____

Gynecologic History:

Number of pregnancies: ____ Age with first delivery: ____ Age with last delivery: ____

Number of vaginal deliveries: ____ Number of C-Sections: ____

Forceps/Vacuum? YES / NO Episiotomy/Tears? YES / NO Baby's Birth Weight: _________

Problems during delivery? YES / NO If yes, please explain: ____

____

Did you experience incontinence during pregnancy? YES / NO

Are your periods regular? YES / NO Abnormally painful? YES / NO If yes, how do you cope with the pain? ____

Have you gone through menopause? YES / NO If yes, at what age? _______

Natural? YES / NO Due to hysterectomy? YES / NO

Do you have a history of yeast infections? YES / NO If yes, how often? _______________________________

Have you had any venereal diseases? YES / NO If yes, what? ____

Any gynecologic problem(s) not already discussed? YES / NO If yes, please explain: __________________

____

____

Emotional History:

Does emotional stress affect your symptoms? YES / NO

Have you ever been diagnosed with and/or treated for a nervous condition? YES / NO

Have you ever been diagnosed with and/or treated for depression? YES / NO

Have you ever experienced domestic violence? YES / NO

Have you ever experienced rape? YES / NO   Date rape? YES / NO

Have you ever experienced sexual abuse/molestation? YES / NO

Symptom Severity:

On a scale of 0 – 10 with 10 being the most severe, what is the current severity of your problem? _________

With 0 being not true at all and 10 being true, rate the following statement as it applies to you today:

"My problem is controlling my life"   Rating: ______

PLEASE COMPLPETE THE FOLLOWING SECTIONS THAT ARE APPLICABLE TO YOUR PROBLEM.
FOR ANY PAIN QUESTIONS, PLEASE REFER TO THIS MANKOSKI PAIN SCALE:

0 – Pain free

1 – Very minor annoyance with occasional minor twinges. No medication needed.

2 – Minor annoyance with occasional strong twinges. No medication needed.

3 – Annoying enough to be distracting. Mild painkillers (such as aspirin or ibuprofen) to take care of pain.

4 – Can be ignored if you are really involved in your work but still distracting. Mild painkillers remove the pain for 3-4 hours.

5 – Can't be ignored for more than 30 minutes. Mild painkillers make the pain better or more tolerable for 3-4 hours.

6 – Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (such as codeine or narcotics) reduce pain for 3-4 hours.

7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.

8 – Physical activity severely limited, you can read and converse with effort. Nausea and dizziness set in as factors of pain.

9 – Unable to speak, crying out or moaning uncontrollably – near delirium.

10 – Unconscious, pain makes you pass out.

Section A: Pelvic/Back Pain

Do you experience pelvic pain? YES / NO   (If no, skip to section B)

If yes, give a description and location of the pain: ____

____

Mark any of the following events that cause pain and rate the severity:

- ☐ During pelvic exam - ___/10
- ☐ Insertion of tampons - ___/10
- ☐ Sitting - ___/10
- ☐ Intercourse - ___/10
- ☐ Certain clothing - ___/10
- ☐ Other: ____ - ___/10

Do you experience back pain? YES / NO   If yes, please rate: ___/10 and describe:_____________________

____

Section B: Voiding Habits

When was the last time you had a urinary tract infection (if any)? ___________________________________

Is your urine ever bloody? YES / NO

Do you feel that you urinate too often? YES / NO

Do you usually get up to urinate during sleeping hours? YES / NO If yes, how many times? ___________

How often do you pass urine during the day? Every _______ hours

Is the volume of urine you usually pass: ___Very small ___Small ___Average ___Large

Do you restrict your fluid intake because of your problem? YES / NO

Do you constantly feel an urge to urinate? YES / NO

Do you often experience a strong, sudden urge to urinate? YES / NO

Do you often feel you must rush to the toilet? YES / NO

How long can you hold back the urge to urinate? ____

Do you lose urine when you have the urge to urinate? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

Do you void before leaving the house "just in case"? YES / NO

Do you have difficulty emptying your bladder completely? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

How do you manage this problem? ____

Is the urine stream ever hesitant or interrupted? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

Do you need to strain to empty? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

Do you have difficulty telling when your bladder is full? YES / NO

Do you dribble just after urinating (when you stand up)? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

Do you have trouble stopping your urine midstream? YES / NO

Section C: Urinary Incontinence

Do you experience uncontrollable loss of urine? YES / NO (If no, skip to Section D)

Do you lose urine with any of the following events: *Please check all that apply*

- ☐ Coughing
- ☐ Sneezing
- ☐ Lifting objects
- ☐ Straining
- ☐ Bending
- ☐ Walking
- ☐ During intercourse
- ☐ After intercourse
- ☐ Other: ________________

Is the volume you lose: ___A few drops ___Wet underwear or pad ___Soaked pad or clothing

Do you lose urine with a strong urge that cannot be controlled? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

Do you ever lose urine without any warning or urge? YES / NO If yes, please explain when/how: ________

____

Do you lose urine without feeling it happen? YES / NO

Do you wear protection for urine loss? YES / NO If yes, what type? _______________________________

Do you experience hygiene or skin problems related to your leakage? YES / NO

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Section D: Bladder Pain

Do you have discomfort associated with your bladder? YES / NO (If no, skip to Section E)

If yes, location/description of pain: ____

Mark any of the following events that cause pain and rate the severity:

- ☐ With bladder fullness - ___/10
- ☐ During voiding - ___/10
- ☐ After voiding - ___/10
- ☐ Other: __________________________-___/10

Section E: Bowel Habits

How often do you have a bowel movement? ____

Do you ever attempt evacuation without results? YES / NO If yes, how often? _______________________

Do you use any of the following to help you evacuate? *Please check all that apply*

- ☐ Suppository
- ☐ Enema
- ☐ Fiber supplement
- ☐ Manual removal
- ☐ Laxatives (Type:_______________________________________)
- ☐ Other: ____

Do you ever experience blood in the stool or on the tissue? YES / NO

What sensation do you experience when you need to evacuate?

___Normal ___Blunted/uncertain ___Strong/urgent

Do you constantly feel an urge to evacuate? YES / NO

Do you lose stool with a strong urge that cannot be controlled? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

How long can you hold the urge to evacuate? __________________________________

Do you have a problem with constipation? YES / NO

Do you strain to pass stool? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

On average, how much time do you spend on the toilet for each evacuation? _______________

Do you have difficulty emptying your bowels completely? YES / NO If yes, when does it occur?

___All of the time ___Most of the time ___Half of the time ___Some of the time

Where do you feel stool remains? ___At the anal opening or ___Higher in the rectum/colon

Do you have difficulty with hygiene after a bowel movement? YES / NO

Section F: Bowel Incontinence

Are you unable to avoid passing gas in public? YES / NO

Do you experience uncontrollable loss of stool or stool seepage? YES / NO (If no, skip to Section G)

Do you lose stool with any of the following events? *Please check all that apply*

- ☐ Coughing
- ☐ Sneezing
- ☐ Lifting
- ☐ Straining
- ☐ Releasing gas
- ☐ Urinating
- ☐ Aerobic exercise
- ☐ Intercourse
- ☐ Other: ________________

Is the amount you lose:

___Stain/smear ___2tbsp or less ___1/4 to ½ cup ___1/2 to 1 cup ___Greater than 1 cup

How often does this happen?____

Section G: Bowel/Abdominal Pain

Do you experience pain related to bowel function? YES / NO   (If no, you have completed this form!)

If yes, location/description of the pain: ____

Mark any of the following events that cause pain and rate the severity:

- ☐ Before bowel movement - ___/10
- ☐ During bowel movement - ___/10
- ☐ After bowel movement - ___/10
- ☐ With meals - ___/10
- ☐ Other: __________________________- ___/10

You have completed this form!

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