Patient Name

DOB:

MR #

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)
PELVIC FLOOR QUESTIONNAIRE

Date:_____

Name of referring MD: _____

May we leave a phone message regarding your therapy? _____

Pain Check all that apply □ Not applicable (skip to next section)

Location of pain: _____

Activities/events that cause or aggravate your symptoms.

☐ Sitting greater than _____ Minutes
☐ Walking greater than _____ Minutes
☐ Standing greater than _____ Minutes
☐ Changing positions (i.e., sit/stand)
☐ Light activity (light housework)
☐ Vigorous activity/exercise (run/weigh lifting/jumping)
☐ Other, please list _____

_____

Pelvic Symptoms

Voiding Habits

1. Number of times urinating in a 24 hour period? _____
2. Number of times getting up at night to urinate? _____
3. Number of times bowel movement? _____per day/week

Urinary Symptoms ☐ Not applicable

☐ Urgency with or preceding urination
☐ Trouble initiating urine stream
☐ Urinary intermittent/slow stream
☐ Trouble emptying bladder
☐ Dribbling after urination leakage
☐ Constant urine leakage
☐ Blood in urine
☐ Painful urination
☐ Trouble feeling bladder urge/fullness
☐ Recurrent bladder infections

Bowel Symptoms ☐ Not applicable

☐ Bowel movement problems
☐ Current laxative use
☐ Trouble feeling bowel/urge/fullness
☐ Constipation
☐ Straining
☐ Trouble holding back gas/feces
☐ Hemorrhoids
☐ Pain with bowel movement
☐ Alternating constipation/diarrhea

Do you sense when you've lost urine? Yes ☐ No ☐

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Bladder leakage-number of episodes

☐ No leakage
☐ Only with physical exertion/cough
Times per day _____
Times per week _____
Times per month _____

Bowel leakage-number of episodes

☐ No leakage
☐ Stool straining
☐ Small amount in underwear
☐ Complete

On Average, how much urine do you leak?

☐ No leakage
☐ Just a few drops
☐ Wets underwear
☐ Wets outerwear
☐ Wets floor

What form of protection do you wear? (Check all that apply)

☐ None
☐ Minimal protection (Tissue paper/paper towel/panty liner)
☐ Moderate protection (Absorbent product, maxi pad)
☐ Maximum protection (Speciality product/diaper)

Sexual symptoms

☐ Not applicable
☐ Currently sexually active
☐ Pain associated with sex

What are your treatment goals? _____

_____

_____

_____

Fluid Intake

# of 8 oz glasses of water per day?_____
# of cups of caffeinated drinks per day? _____
Amount of alcohol consumed in a typical week? _____

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General History

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?
Yes ☐ No ☐

During the past month have you been feeling down, depressed, or hopeless?_____

During the past month, have you been bothered by having little interest or pleasure in doing things? _____

Current level of stress? ☐ High ☐ Med ☐ Low

(Females Only)
Last date of last pelvic exam? _____

☐ Children by vaginal deliveries # _____

☐ Episiotomy # _____

☐ C-Section # _____

☐ Abdominal or pelvic surgeries # _____

☐ Vaginal dryness

☐ Painful periods

☐ Menopause-when? _____

(Males only)
Last date of prostate exam? _____

☐ Prostate disorders

☐ Erectile dysfunction

☐ Painful ejaculation

☐ Abdominal or pelvic surgeries? _____