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 for largest baby_____ **Number of cesarean deliveries**_____

Number of episiotomies_____ **Date of last pap smear**_____

Did you have any trouble healing after delivery **Y** **N**

Do you have a history of sexual abuse or trauma **Y** **N**

Are you having regular periods/menstrual cycles **Y** **N**

Do you have frequent urinary tract infections **Y** **N**

Pain

Do you have pain with:

Sexual intercourse **Y** **N**

Pelvic Exam **Y** **N**

Tampon use **Y** **N**

Back, leg, groin, abdominal pain **Y** **N**

Test Results

Urodynamics Test **Y** **N**

Results: _____

Cystoscope **Y** **N**

Results: _____

Urine Test **Y** **N**

Results: _____

Bowel test **Y** **N**

Results: _____

Bladder symptoms

Do you lose urine when you:

Cough/sneeze/laugh	**Y**	**N**	**Lift/exercise/dance/jump**	**Y**	**N**
On the way to the bathroom	**Y**	**N**	**Have a strong urge to urinate**	**Y**	**N**
Hearing running water	**Y**	**N**	**Straining to empty bladder**	**Y**	**N**
Do you wet the bed	**Y**	**N**	**Have burn/pain with urination**	**Y**	**N**
Have a falling out feeling	**Y**	**N**	**Difficult to start urinating**	**Y**	**N**
Pain with a full bladder	**Y**	**N**	**Urinate more than 7x/day**	**Y**	**N**

Other _____

Bowel symptoms

Leaking/straining feces	**Y**	**N**	**Strain for a bowel movement**	**Y**	**N**
Leaking gas by accident	**Y**	**N**	**Have diarrhea often**	**Y**	**N**
Take laxatives/edema regularly	**Y**	**N**	**Include fiber in your diet**	**Y**	**N**
Pain with bowel movement	**Y**	**N**	**Strong urge to move bowel**	**Y**	**N**

How often to you move your bowels _____ per (day, week)

Most common stool consistency ___liquid ___soft ___firm ___pellets ___other_____

Please circle any of the following health conditions that you now have or had in the past.

a. None
b. Cancer
c. Diabetes
d. High blood pressure
e. Heart problems
f. Rheumatoid arthritis
g. Osteoarthritis
h. Asthma
i. Emphysema
j. Over weight
j. Unexplained weight loss
k. Chemical dependency
l. Smoker
m. Seizures
n. Currently pregnant
o. # of pregnancies____
p. # of deliveries ____
q. Thyroid disease
r. Multiple sclerosis
s. Hepatitis
u. Tuberculosis
v. Kidney disease
w. Anemia
x. Stroke
y. Osteoporosis
z. History of fractures
aa. Menopausal
bb. Incontinence
cc. Depression
dd. Mental Illness
ee. Other _____

Please list any medications that you are taking (over the counter and prescriptions) and list the dosage. (Please be very specific.)

Medication	**Dosage**

_____

Please list any surgeries you have had or circle no surgeries:

k. No surgeries or not related to current information. Date:

_____

_____

_____

_____