

PELVIC FLOOR THERAPY QUESTIONNAIRE

Name _____ Date _____

History

Number of:

Pregnancies _____ Vaginal deliveries _____ Cesarean deliveries _____ Episiotomies _____

Date of Last:

Pap smear _____ Menstrual cycle _____ Birth weight of largest baby _____

Did you have any trouble healing after deliver Y N

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

Are you having regular periods 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 or abdominal Y N

Bladder Symptoms

Do you lose urine when you:

Cough/sneeze/laugh Y N

On the way to the bathroom Y N

Hear running water Y N

Lift/exercise/dance/jump Y N

Have a strong urge to urinate Y N

Other _____ Y N

Do you wet the bed Y N

Have burning/pain w/urination Y N

Strain to empty your bladder Y N

Have a falling out feeling Y N

Have an urgency of urination Y N

Difficulty starting a stream of urine Y N

Feel unable to empty bladder fully Y N

Have pain w/a full bladder Y N

Urinate more than 7 times daily Y N

Bowel Symptoms

Strain to have a bowel movement Y N

Include fiber in your diet Y N

Take laxatives/enema regularly Y N

Have a very strong urge to move your bowels Y N

Leak/strain feces Y N

Have diarrhea often Y N

Leak gas by accident Y N

Have pain w/bowel movement Y N

How often do you move your bowels per day/week _____/_____

Most common stool consistency:

liquid _____ soft _____ firm _____ pellets _____ other _____