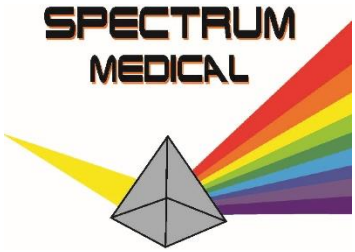

PELVIC FLOOR THERAPY QUESTIONNAIRE

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?	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:	Y	N
Sexual Intercourse?	Y	N
Pelvic Exam?	Y	N
Tampon Use?	Y	N
Back/leg/groin/ abdominal pain?	Y	N

TEST RESULTS			**RESULTS**
Urodynamics test	Y	N	_____
Cytoscope	Y	N	_____
Urine Test	Y	N	_____
Bowel Test	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
Do you wet the bed?	Y	N
Have burning/pain w/ urination?	Y	N
Difficulty starting a stream of urine?	Y	N
Strain to empty your bladder?	Y	N
Feel unable to empty bladder fully?	Y	N
Have a falling out feeling?	Y	N
Have pain with a full bladder?	Y	N
Have an urgency of urination (a strong urge to urinate)?	Y	N
Urinate more than 7 times a day?	Y	N
Lift/exercise/dance/jump	Y	N
Have a strong update to urinate	Y	N

Other _____

BOWEL SYMPTOMS

Strain to have a bowel movement?	Y	N
Include fiber in your diet?	Y	N
Take laxative/enema regularly	Y	N
Have pain w/ bowel movement	Y	N
Have a very strong urgency to move your bowels?	Y	N
Leak/stain feces?	Y	N
Have diarrhea often?	Y	N
Leak gas by accident?	Y	N
How often do you move your bowels?	Y	N

Most common stool consistency

_____liquid _____soft _____firm _____pellets _____Other:_____

Thank you for taking the time to complete this questionnaire