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Pelvic Floor Distress Inventory – Short Form 20

Name _____ Date of Birth _____ Today's Date _____

Height _____ ft. _____ in. Weight _____ lbs.

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer each question by putting a check mark in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can.

While answering these questions, please consider your symptoms over **the last 3 months**.

			If YES, how much does it bother you?			
			Not At All	Somewhat	Moderately	Quite A Bit
1	Do you usually experience pressure in the lower abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
2	Do you usually experience heaviness or dullness in the lower abdomen?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
4	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
5	Do you usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
6	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
7	Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
8	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
9	Do you usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
10	Do you usually lose stool beyond your control if your stool is loose or liquid?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
11	Do you usually lose gas from the rectum beyond your control?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
12	Do you usually have pain when you pass your stool?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
13	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
14	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
15	Do you usually experience frequent urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
16	Do you usually experience urine leakage associated with a feeling of urgency (i.e. a strong sensation of needing to go to the bathroom)?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
17	Do you usually experience urine leakage related to laughing, coughing, or sneezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
18	Do you usually experience small amounts of urine leakage (i.e. drops)?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
19	Do you usually experience difficulty emptying your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
20	Do you usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

SCORE _____