



Patient History

Name _____ Age _____ Date _____

1. Describe the current problem that brought you here? _____

2. When did your problem first begin? _____ months ago or _____ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

4. Since that time is it: staying the same _____ getting worse _____ getting better
Why or how? _____

5. If pain is present rate pain on a 0-10 scale 10 being the worst. _____ Describe the nature of
the pain (i.e., constant burning, intermittent ache) _____

6. Describe previous treatment/exercises _____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

<input type="checkbox"/> Sitting greater than _____ minutes	<input type="checkbox"/> With cough/sneeze/straining
<input type="checkbox"/> Walking greater than _____ minutes	<input type="checkbox"/> With laughing/yelling
<input type="checkbox"/> Standing greater than _____ minutes	<input type="checkbox"/> With lifting/bending
<input type="checkbox"/> Changing positions (i.e., sit to stand)	<input type="checkbox"/> With cold weather
<input type="checkbox"/> Light activity (light housework)	<input type="checkbox"/> With triggers (running water/key in door)
<input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump)	<input type="checkbox"/> With nervousness/anxiety
<input type="checkbox"/> Sexual activity	<input type="checkbox"/> No activity affects the problem
<input type="checkbox"/> Other, please list _____	

8. What relieves your symptoms? _____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

11. What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe _____		

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries # _____	Y/N	Vaginal dryness
Y/N	Episiotomy # _____	Y/N	Painful periods
Y/N	C-Section # _____	Y/N	Menopause - when? _____
Y/N	Difficult childbirth # _____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Other /describe _____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe _____		

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Problems

Y/N	Trouble initiating urine stream	Y/N	Blood in urine
Y/N	Urinary intermittent /slow stream	Y/N	Painful urination
Y/N	Trouble emptying bladder	Y/N	Trouble feeling bladder urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Current laxative use
Y/N	Trouble emptying bladder completely	Y/N	Trouble feeling bowel/urge/fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections
Y/N	Other/describe _____		

1. Frequency of urination: awake hour's _____ times per day, sleep hours _____ times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
_____ minutes, _____ hours, _____ not at all
3. The usual amount of urine passed is: ___small ___medium___ large.
4. Frequency of bowel movements _____ times per day, _____ times per week, or _____.
5. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?
_____ minutes, _____ hours, _____ not at all.
6. If constipation is present describe management techniques _____
7. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? _____ glasses per day.
8. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
___ None present
___ Times per month (specify if related to activity or your period)
___ With standing for _____ minutes or _____ hours.
___ With exertion or straining
___ Other

Skip questions if no leakage/incontinence

9a. Bladder leakage - number of episodes

- ___ No leakage
- ___ Times per day
- ___ Times per week
- ___ Times per month
- ___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes

- ___ No leakage
- ___ Times per day
- ___ Times per week
- ___ Times per month
- ___ Only with exertion/strong urge

10a. On average, how much urine do you leak?

- ___ No leakage
- ___ Just a few drops
- ___ Wets underwear
- ___ Wets outerwear
- ___ Wets the floor

10b. How much stool do you lose?

- ___ No leakage
- ___ Stool staining
- ___ Small amount in underwear
- ___ Complete emptying

11. What form of protection do you wear? (Please complete only one)

- ___ None
 - ___ Minimal protection (Tissue paper/paper towel/pantishields)
 - ___ Moderate protection (absorbent product, maxipad)
 - ___ Maximum protection (Specialty product/diaper)
 - ___ Other _____
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On average, how many pad/protection changes are required in 24 hours? _____ # of pads