kinetix PHYSICAL THERAPY
2783 SW 87th Drive, Suite 102, Gainesville, FL 32608
352-505-6665

Name: _____

Date: _____

Female Pelvic Dysfunction Questionnaire

DOB _____ Age _____ Height _____ Weight _____

Social History: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Work Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Please answer the questions below to the best of your ability. This form addresses bowel/ bladder and pelvic pain symptoms related to the pelvic floor musculature. There may be a portion of the questionnaire that does not pertain to your condition – you may skip those areas.

Describe the reason for your appointment _____

_____

When did this problem begin? _____ Is it getting (circle best answer) better/worse/same?

BLADDER SYMPTOMS

Do you have urinary incontinence Yes / No **(Answer the below section if you answered yes)**

1. **Bladder leakage frequency** (average number of leaks): _____ # per (circle one) month / week / day / constant / none
2. **Severity of leakage** (circle one): No leakage / Few drops / Wets underwear / Wets outerwear
3. **Protection worn** (circle one): None / Tissue paper or paper towel / Guards / Depends/ Diaper / Diaper + **# per day** _____
4. Do you have **Bladder leakage caused by or increased by** (check all that apply):

___ Vigorous activity or exercise (running, weight lifting, lifting around the house)
___ Coughing/Sneezing/Laughing
___ Light activity (walking, light house work)
___ Changing positions (from sitting to standing)
___ Walking to the toilet
___ Other, please list _____

___ Intercourse or sexual activity
___ No activity changes leakage (constant leakage)
___ After emptying bladder
___ Washing hands/Hearing water run
___ Putting key in lock
___ Strong urge to urinate

5. **What position does leakage occur in** (circle all that apply): Lying down / Sitting / Standing / Squatting
6. **Fluid intake** (one glass is 8oz. or one cup)

# of water glasses per day _____ # of caffeinated glasses per day _____ # of alcoholic beverages per day _____

7. How often do you urinate during the day? _____ # or average time between trips to the bathroom _____
8. How often do you urinate after going to bed? (# of times) _____
9. Is the volume of urine passed usually (circle one): Large / Average / Small / Very small
10. Yes / No Can you stop the flow of urine when on the toilet?
11. Yes / No Do you have the sensation that you need to go to the toilet?
12. Yes / No Have you had any bladder infections in the last year? If so, how many _____
13. Yes / No Do you strain to pass urine?
14. Yes / No Do you empty your bladder frequently, before you experience the urge to pass urine?
15. Yes / No Do you have the feeling your bladder is still full after urinating?
16. Yes / No Do you lose a few drops of urine after you feel like you have emptied your bladder?
17. Yes / No Do you have a slow, hesitant urinary system?

18. Yes / No Do you have difficulty initiating the urine stream?

19. Yes / No Does your urine stream stop and start?

20. How long can you delay the need to urinate? (circle one)

Not at all / 1-2 min / 3-10 min / 11-30 min / 31-60 min / _____ hours

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BOWEL SYMPTOMS

Do you have fecal incontinence Yes / No **(Answer the below section if you answered yes)**

1. a) **Bowel leakage frequency** (average number of leaks): _____ # per (circle one) month / week / day / constant / none

2. **Severity of leakage** (circle one): No leakage / Few drops / Wets underwear / Wets outerwear

3. **Protection worn** (circle one): None / Tissue paper or paper towel / Guards / Depends/ Diaper / Diaper + **# per day** _____

4. **What position does leakage occur in** (circle all that apply): Lying down / Sitting / Standing / Squatting

5. Frequency of bowel movements: _____ times per day _____ times per week

6. Consistency of stool (circle one): Loose / Normal / Hard

7. Yes / No History of constipation?

8. Yes / No Do you currently strain to go?

9. Yes / No Do you ignore the urge to defecate?

10. Yes / No Do you have trouble making it to the toilet on time when you have the urge to defecate?

11. If **Bowel leakage, present, it occurs with** (check all that apply):

___ Urge to defecate with normal stool ___ Exercise/Cough/Sneeze/Laugh ___ No loss of stool
___ Urge to defecate with loose stool ___ Seepage of stool after bowel movement ___ No known cause

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PELVIC PAIN

Do you have pelvic pain? Yes / No **(Answer the below section if you answered yes)**

1. Do you have pain with urination? Yes / No
2. Do you have pain with intercourse? Yes / No (circle all that apply): Initial penetration / Deep penetration / Constant
3. Do you have pain with insertion of tampon? Yes / No

1. Rate your pain level on a scale of 0 to 10. (0 = no pain; 10 = worst pain)

Best _____/10 Worst _____/10 Current _____/10

5. Do you have pain in the (circle all that apply) Vagina / Labia / Clitoris / Perineum / Bladder / Lower pelvic region

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CURRENT LEVEL OF FUNCTION

How restricted are your normal activities due to Bowel/Bladder/Pain issues? (circle one)

Unrestricted / Mildly Restricted / Moderately Restricted / Completely Restricted

Specifically, what are you having difficulty or pain with performing?

Rate your feelings as to the severity of your problem from 0-10 (circle the number that applies):

(not a problem) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (major problem/ affects daily function)

MEDICAL HISTORY

Answering the following questions will help us to manage your care better.

Date of last doctor visit _____ **Last pelvic exam** _____ **Last urinalysis** _____

Previous tests for the condition for which you are coming to physical therapy? (List tests, i.e. urodynamics, ultrasound, etc.)

Test _____ Date _____

Test _____ Date _____

Do you now have or have you ever had a history of the following? (check all that apply)

___ Abdominal pain
___ Allergy to **Latex**
___ Allergies
___ Asthma
___ Bladder cancer
___ Bladder infections
___ Blood in urine
___ Broken bones
___ Childhood bladder problem
___ Other (please list) _____

___ Injuring tail bone
___ Diabetes
Do you use insulin? Yes / No
___ Emphysema/bronchitis
___ Fecal incontinence
___ Heart disease
___ Hemmorhoids/anal fissures
___ High blood pressure
Do you require diuretics? Yes / No

___Chronic coughing/ sneezing
___ Joint problems
___ Low back pain/sciatica
___ Multiple sclerosis
___ Pain during intercourse
___ HIV/ AIDS
___ Sexually transmitted disease
___ Smoking habit
___ Stroke

Allergies to any medications? _____

Medications	How often do you take it	Dosage (mg, mcg, etc.)	Route of Administration (oral, topical, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SURGICAL HISTORY

___ Surgery for abdominal organs Date _____
___ Surgery for your back/spine Date _____
___ Surgery for your bladder Date _____
___ Surgery for your brain Date _____
___ Other surgeries (please describe): _____ Date _____
___ Other types of interventions (please describe): _____ Date _____

___ Chemotherapy Date _____
___ Radiation Date _____
___ Heart surgery Date _____

OB/GYN HISTORY

___ Pregnancies # _____ Are you currently pregnant? Yes / No Vaginal Deliveries #_____ C-sections #_____
Difficult child birth: Yes / No ___ Episiotomy # _____ ___ Painful periods
___ Menopause? Date _____ ___ Prolapse, downward movement of bladder, bowel, uterus

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What are your goals for physical therapy? _____

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