WASATCH
PHYSICAL THERAPY
Back to life

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PELVIC SYSTOM QUESTIONNAIRE **Name: ____**

Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream
Y/N Urinary intermittent / slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge/fullness
Y/N Current laxative use
Y/N Trouble feeling bowel/urge/fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
Y/N Recurrent bladder infections

Y/N Other/describe ____

1. **Frequency of urination: awake hours_____ 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 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 episode
_____ 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 to 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 ____
On average, how many pad/protection changes are required in 24 hours? _____ # of pads

Pg 2 Pg 2 History **Name** ____

General Health: Excellent Good Average Fair Poor Occupation ______________________________
Hours/week _____ On disability or leave? _____ Activity restrictions? ______________________________

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+days/week
Describe ____

Mental Health: Current level of stress High_____ Med _____ Low _____ Current psych therapy? Y / N
Have you ever had any of the following conditions or diagnoses? Circle all that apply/describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart Problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid
Low back pain	Chronic Fatigue syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic condition	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint replacement	Sexually transmitted disease
Smoking history	Bone fracture	Physical or Sexual abuse
Vision/eye problems	Sports injury	Raynaud's (cold hand and feet)
Hearing loss/problems	TMJ/neck pain	Pelvic pain
Other/Describe		

____

Surgical / Procedure History
Y/N Surgery for your back/spine
Y/N Surgery for your brain
Y/N Surgery for your female organs
Y/N Surgery for your bladder/prostrate
Y/N Surgery for your bones/joints
Y/N Surgery for your abdominal organs
Other/Describe ____

Ob/Gyn History (females only)
Y/N Childbirth vaginal deliveries #_____
Y/N Episiotomy #_____
Y/N C-Section #_____
Y/N Difficult childbirth #_____
Y/N Prolapse or organ falling out
Y/N Vaginal Dryness
Y/N Painful periods
Y/N Menopause – when? _____
Y/N Painful vaginal penetration
Y/N Pelvic pain
Other/Describe ____

Males Only
Y/N Prostrate disorders
Y/N Shy bladder
Y/N Pelvic pain
Y/N Erectile dysfunction
Y/N Painful ejaculation
Other Describe ____

Medication – pills, patch	**Start date**	**Reason for taking**
____________	____________	____________
____________	____________	____________
____________	____________	____________

Over the counter–Vitamins etc	**Start date**	**Reason for taking**
____________	____________	____________
____________	____________	____________
____________	____________	____________