

BIOGRAPHIC INFORMATION

Name: _____ Date: _____

Age: _____ Race: _____ Date of Birth: _____ Height: _____ Weight: _____

Reason for your visit	Your current address and phone number
_____	_____
_____	_____
_____	_____

REFERRAL INFORMATION

Referring Doctor or Nurse and Address/Phone	Primary Doctor or Nurse and Address/Phone
_____	_____
_____	_____
_____	_____

SYMPTOM QUESTIONNAIRE

In order to understand the nature of your pelvic floor concerns more clearly, we ask that you please answer the following questions. Each question tries to uncover specific aspects of incontinence or pelvic prolapse, and will help us make a diagnosis and treatment plan.

Section 1:

1. When I need to urinate, I experience an urgency so intense that I must rush to the toilet:
 always often half the time rarely never
2. I experience leakage of urine. Yes No **(if no, go to question 6)**
 How long have you experienced leakage of urine? _____ years _____ months
3. I leak urine when I do the following things **(check all that apply)**:
 cough sneeze lift bend over laugh walk run none of these
 How often? _____ times per day week month
4. I leak urine when I do the following things **(check all that apply)**:
 hear running water unlock the door go into cold weather
 rush to the toilet when I have a strong urge to urinate
 none of these
 How often? _____ times per day week month
5. I leak urine for no reason at all.
 always often half the time rarely never
6. During the day I urinate every _____ minutes hours.

SYMPTOM QUESTIONNAIRE CONTINUED

- | | Always | Often | Half the time | Rarely | Never |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 7. My bladder awakens me at night to urinate. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. When I am finished urinating, my bladder feels empty. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. I need to push hard to empty my bladder. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I do Kegel exercises. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section 2:

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. I feel as if there is something bulging into my vagina or coming out of my vagina. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I experience pelvic discomfort when standing or during physical exertion. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have to push on the vaginal walls to empty my bladder. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I use a pessary. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section 3:

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. I feel an urge when I need to have a bowel movement. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. When I need to have a bowel movement, the urge is so intense that I must rush to the toilet. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I often have the urge to have a bowel movement and am unable. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I feel that having a bowel movement does not completely empty my rectum. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I use my fingers in my vagina or rectum to help with bowel movements. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If I have to pass gas, I can hold it for a short time. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Stool comes out when I am not on the toilet. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. I have trouble with constipation. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. I have _____ bowel movements per <input type="checkbox"/> day <input type="checkbox"/> week. | | | | | |

Section 4:

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. I am sexually active. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 2. Sexual intercourse is painful for me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In my life, I have been sexually or physically abused. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 4. I leak urine with sexual relations. <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, this has affected my sexual interest. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 5. I have other questions about sexual intercourse. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

OTHER SYMPTOMS

Currently you are having problems with (check symptoms):

- | | | | | |
|--------------------------|--|---|---|---|
| General: | <input type="checkbox"/> fevers | <input type="checkbox"/> chills | <input type="checkbox"/> decreased energy | <input type="checkbox"/> weight loss |
| Eyes: | <input type="checkbox"/> visual disturbances | <input type="checkbox"/> problems with glaucoma | <input type="checkbox"/> dry eyes | |
| Ears,nose,throat: | <input type="checkbox"/> sinus problems | <input type="checkbox"/> chronic colds | | |
| Cardiovascular: | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> palpitations | <input type="checkbox"/> chest pain | <input type="checkbox"/> swelling in legs |
| Respiratory: | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> chronic cough | | <input type="checkbox"/> asthma |
| Gastrointestinal: | <input type="checkbox"/> diarrhea | <input type="checkbox"/> constipation | <input type="checkbox"/> heartburn | <input type="checkbox"/> bleeding |
| Musculoskeletal: | <input type="checkbox"/> joint pain | | | |
| | <input type="checkbox"/> back pain | | | |
| Emotional: | <input type="checkbox"/> depression | <input type="checkbox"/> anxiety | <input type="checkbox"/> mental changes | <input type="checkbox"/> emotional changes |
| Endocrine: | <input type="checkbox"/> excessive thirst | | | |
| | <input type="checkbox"/> hot spells or difficulty staying warm | | | |
| Hematologic: | <input type="checkbox"/> excessive bruising | | <input type="checkbox"/> bleeding | <input type="checkbox"/> blood clots in veins |
| Other: | _____ | | | |

OBSTETRIC AND GYNECOLOGIC HISTORY

Number of pregnancies: _____

Number of children born: _____

Number of cesarean sections: _____

Weight of largest infant: _____

During your deliveries, did you ever have a tear into the rectum? Yes No

Were forceps or a vacuum ever used? Yes No

Have you experienced menopause? Yes No

If yes, are you taking hormone replacement? Yes No

If no:

Date of last menstrual period _____

Are you having problems with your periods? Yes No

Date of last pap smear _____

Was it normal? Yes No

Date of last mammogram _____

Was it normal? Yes No

Date of last colon screening (colonoscopy/sigmoidoscopy) _____

Was it normal? Yes No

SURGICAL HISTORY

List all surgeries and the approximate dates:

Surgery:

Date:

FAMILY HISTORY

Please note if you have a family history of any of these diseases:

					Family Member
Breast cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Ovarian cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Other cancer: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Heart disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Hypertension	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____
Other: _____					_____

DAILY ACTIVITIES

What kind of work do you do? _____

Who is your main support person (partner/spouse/friend)? _____

Do you consider yourself healthy? Yes No

Have you ever smoked? Yes No

Starting at what age? _____

Ending at what age? _____

How many packs per day? _____

How many glasses of beer, wine, or other alcohol do you drink per day? _____

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____

Level of physical activity:

- Get regular aerobic exercise such as jogging and aerobics
- Able to do aerobic exercise but do not do it regularly
- Walk without assistance
- Require assistance to walk
- Use a wheelchair

Some women find that accidental urine loss and/or prolapse (falling or dropping of the uterus, vagina, bladder, or bowels) may affect their activities, relationships, and feelings. The questions below refer to areas in your life which may have been influenced or changed by your problem. For each question, check the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage and/or prolapse.

Has urine leakage and/or prolapse affected your:

	Not at all	Slightly	Moderately	Greatly
Ability to do household chores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical recreation such as walking, swimming, or other exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Entertainment activities (movies, concerts, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to travel by car or bus more than 30 minutes from your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participation in social activities outside your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional health (nervousness, depression, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment outside the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DAILY ACTIVITIES CONTINUED

The following symptoms have been described by women who experience accidental urine loss and/or prolapse. Please indicate which symptoms you are now experiencing, and how bothersome they are for you. Be sure to answer all questions by checking the appropriate space which best describes how you feel.

Do you experience, and if so, how much are you bothered by:

	Not at all	Slightly	Moderately	Greatly
Frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine leakage related to the feeling of urgency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine leakage related to physical activity, coughing, or sneezing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small amounts of urine leakage (drops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or discomfort in the lower abdominal or genital area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A feeling of bulging or protrusion in the vaginal area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulging or protrusion you can see in the vaginal area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having to push on the vaginal walls with your fingers to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>