

# Bay Area Physical Therapy & Wellness

3637 Cortez Rd. W. Ste. 103, Bradenton, FL 34210

1401 8th Ave. W. Ste. A, Palmetto, FL 34221



## Pelvic Floor Questionnaire

Name: \_\_\_\_\_ Sex: Male Female Date: \_\_\_\_\_

1. Please describe your main problem: \_\_\_\_\_  
\_\_\_\_\_
2. When did it begin? \_\_\_\_\_ Symptoms are: (circle one) Getting Worse Improving Unchanged
3. Please describe activities or things you cannot do because of your problem: \_\_\_\_\_  
\_\_\_\_\_
4. Have you had any treatment for this problem before? \_\_\_\_\_ If so, did it help? YES / NO
5. How long can you delay the need to urinate? Indefinitely  1+hr.  ½ hr.  15 min.  1-2 min.  Not at all
6. Position or activity with leakage (Please check all that apply):  
Lying  Sitting  Standing  Changing positions (sit to stand)  Intercourse  Strong Urge
7. Activity level that causes urine loss: Vigorous  Moderate  Light  No Activity
8. Do you experience an urge to urinate when you hear running water? YES/ NO
9. Can you stop your stream? YES/ NO      10. Do you have difficulty initiating your stream? YES/ NO
11. Do you have blood in your urine? YES/ NO      12. Do you have to strain to empty your bladder? YES/ NO
13. Do you dribble when you are urinating? YES/ NO After you empty your bladder? YES/ NO
14. How many times do you urinate? Per day \_\_\_\_\_ Per night \_\_\_\_\_
15. Do you wear protection? YES/ NO If so, what kind? Panty shields Mini-pad Maxi-pad Diaper/Serenity
16. Bowel Habits: How often do you have a bowel movement? \_\_\_\_\_ Are you ever constipated? YES/ NO  
How is it resolved? Do you use: Laxatives  Stool Softeners  Enemas   
Do you ever experience diarrhea? \_\_\_\_\_ Do you take anything for it? YES/ NO
17. Daily fluid intake: # of cups per day \_\_\_\_\_ Of those, how many are carbonated or caffeinated? \_\_\_\_\_  
Do you restrict fluids because of incontinence? YES/ NO
18. Mobility/self-care: Do you use a cane or walker? YES/ NO Do you have balance difficulties? YES/ NO
19. Are you sexually active? YES/ NO
20. Do you have or have you ever had a sexually transmitted disease? YES/ NO When? \_\_\_\_\_ Type? \_\_\_\_\_
21. Pain or problems with intercourse or urination? YES/ NO Describe: \_\_\_\_\_  
\_\_\_\_\_
22. Do you have any back pain? YES/ NO If so, explain: \_\_\_\_\_
23. Overall , how much does your condition interfere with your everyday life?

Please circle a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10  
not at all moderate a great deal

**1. How often do you leak urine?** (Tick one box)

- Never  · 0  
About once a week or less often  · 1  
Two or three times a week  · 2  
About once a day  · 3  
Several times a day  · 4  
All the time  · 5

**2. We would like to know how much urine you think leaks.**

**How much urine do you usually leak (whether you wear protection or not)?** (Tick one box)

- None  · 0  
A small amount  · 2  
A moderate amount  · 4  
A large amount  · 6

**3. Overall, how much does leaking urine interfere with your everyday life?**

Please circle a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10  
not at all a great deal

(For Office Use) ICIQ score: sum scores 1 + 2 + 3 = \_\_\_\_\_

**When does urine leak?** (Please tick all that apply to you)

- Never – urine does not leak   
Leaks before you can get to the toilet   
Leaks when you cough or sneeze   
Leaks when you are physically active/exercising   
Leaks when you have finished urinating and are dressed   
Leaks for no obvious reason   
Leaks all the time

**WOMEN ONLY**

Gynecological History: # of children? \_\_\_\_\_ Type of delivery? Vaginal/ C-Section/ Both

# of episiotomies? \_\_\_\_\_ Do you have a painful episiotomy scar? YES/ NO

Do you have a history of urinary tract infections? YES/ NO

Do you have history of urine loss as a child? YES/ NO Adolescent? YES/ NO or after child birth? YES/ NO

Are you pregnant or attempting to get pregnant? YES/ NO When was your menopause onset? \_\_\_\_\_

Have you been on Hormone Replacement Therapy? \_\_\_\_\_ (If yes, please list type of dosage below)

Estrogen \_\_\_\_\_ Progesterone \_\_\_\_\_ Pills \_\_\_\_\_ Patch \_\_\_\_\_ Cream \_\_\_\_\_

What was the date of your last pelvic exam? \_\_\_\_\_

Do you experience a falling out feeling? YES/ NO If so, when? (circle below)

Occasionally with menses At the end of the day Pressure with straining Peroneal pressure all day

**MEN ONLY**

When was your last prostate exam? \_\_\_\_\_ What was your PSA? \_\_\_\_\_

Do you have pain? (Circle all that apply) During Intercourse After bowel movement During Ejaculation

Any comments or concerns not covered? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_