Pelvic Floor Questionnaire

FABIAN
PHYSICAL THERAPY LLC
Erika Fabian PT, FCAMPT
95 Lono Avenue, Suite 202, Kahului, Hawai'i 96732
Tel 808.872.3333 Fax 808.872.3332
Email erika@fabianpt.com

Name:_____ Birthdate:___/___/___ Date:_____
Physician: _____
Please describe your main problem:_____
_____

When did it begin?:_____Is it getting: better, worse, or staying the same (circle one)
Please describe activities or things you can not do because of your problem_____
_____
Please list all pelvic and abdominal surgeries with dates of operation.
_____
_____
Date of last pelvic examination:_____Date of last urinalysis:_____
Special tests performed?_____Type:_____Date:_____
Was there an event associated with the onset of your complaints? _____
_____

OCCURANCE OF INCONTINENCE OR LEAKAGE: Never___ Less than 1/month___ More than 1/month___
Less than 1/week___ More than 1/week___ Almost everyday___ Number of leaks per day___

PROTECTION USED: No protection ___ Panti shields___ Mini pads___ Maxi pads___
Bladder control pad type_____ Diaper___

SEVERITY: No leakage___ Few drops___ Wet underwear___ Wet outerwear___

POSITION OR ACTIVITY WITH LEAKAGE: Lying down___ Sitting___ Standing___ Changing positions (sit to stand)___
Sexual activity___ String urge___

HOW LONG CAN YOU DELAY THE NEED TO URINATE?: Indefinitely___ 1+ hours___ ½ hour___15 minutes___
Less than 10 minutes___ 1-2 minutes___ Not at all___

ACTIVITY THAT CAUSES URINE LOSS: Vigorous activity___ Moderate activity___ Light activity___
No activity___ Type_____

PROLAPSE (Falling out feeling): Never___ Occasionally/with menses___ Pressure at the end of the day___
Pressure with straining___ Pressure with standing___ Perineal pressure all day__

FREQUENCY OF URINATION (DAYTIME): 0 times per day___ 1-4___ 5-8___ 9-12___13+___

FREQUENCY OF URINATION (NIGHTIME): 0 times per night___ 1___ 2___ 3___ 4+___

FLUID INTAKE (includes water and beverages): 9+-8oz glasses/day___
8-6 8oz glasses/day____ 3-5 8oz glasses/day___ 1-2 8pz glasses/day___ How many caffeinated glasses?_____

FREQUENCY OF BOWEL MOVEMENTS: 2 times/day___ 1 time/day___ Every other day___ Once every 4-7 day___ Weekly___

AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?
Can stop completely___ Can maintain a deflection of the deflection of the stream____
Can partially deflect the urine stream___ Unable to deflect or slow the stream____

DO YOU HAVE TROUBLE INITIATING A URINE STREAM?
Never___ More than 1/month___ Less than 1/week ___ Almost everyday ___
Do you have pain on urination or during a bowel movement?: Yes____ No____
Any dribbling after urination?: Yes ____ No____

ATTITUDE TOWARD THE PROBLEM: No problem___ Minor inconvenience___ Slight problem___
Moderate problem___Major problem ___

CONFIDENECE IN CONTROLLING YORU PROBLEM: Complete confidence___ Moderate confidence___
Little confidence___ No confidence___

Does this problem affecting your work, recreation or fluid intake?: No___
If yes please describe_____
Are you sexually active? Yes ____ No ____
Are you pregnant or attempting pregnancy? Yes____ No ____
Number of pregnancies?_____ Complications?_____
_____
History of, or present sexually transmitted diseases? Type?:_____
_____

Do you have pain or problems with sexual activity or urination? Describe:_____
_____

Have you ever been taught or prescribed to do pelvic floor / Kegel exercises?
Yes ____ No ___ When? _____ By whom? _____
How often do you do pelvic floor exercises?_____

Any comments or concerns not asked?
_____
_____

What are your goals?
_____
_____
_____
_____
_____
_____