Pelvic Floor Therapy Questionnaire

PATIENT NAME: ____________________________DATE:___________________

Please fill in the following questionnaire to the best of your ability.

Date of last pelvic exam/pap: **Date of last urinalysis**:

Have you had any previous treatment for incontinence? Yes ☐ No ☐
If yes, please explain how effective it was:

____

MEDICATIONS (please list all medications you are presently taking including vitamins and supplements):
____

____

SURGERIES:____

____

OBSTETRICAL HISTORY:

Number of pregnancies _____________ Number of vaginal deliveries __________

Birth weight of largest baby _________ Number of caesarean deliveries ________

Number of episiotomies ____________ Year of children(s) birth(s)______________

Circle if yes: forceps breech tears other:

EXERCISE:

Do you get any regular exercise? Yes ☐ No ☐

If yes, what do you do? ____

Are stress or anxiety affecting your life? If so, please explain.

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Please circle Y=yes or N=no for history of any of the following:

Y N Did you have any trouble healing after delivery
Y N Osteoporosis
Y N Bladder infections
Y N Pelvic/abdominal pain
Y N Low back pain
Y N Sexually transmitted disease
Y N Menopause
Y N Are you having regular periods/ menstrual cycles
Y N Sexual abuse or trauma
Y N Physical abuse
Y N Irritable bowel syndrome
Y N Constipation
Y N Cancer
Y N Diabetes
Y N Neurological problems such as: Stroke, Parkinson's, Multiple Sclerosis, Head injury
Y N Blood in stool
Y N Blood in urine

Please explain the above responses and add any more information not yet asked:

GOALS FOR TREATMENT (your expectations):

____

____

____

RATE YOUR PROBLEM:

0 __________________ 5 __________________ 10

0 means no problem & 10 means it really interferes with your life or bothers you a lot.