PELVIC HEALTH QUESTIONNAIRE FORM

OSTI
Orthopedic and Sports Therapy Institute

Please check which clinic you will be attending therapy.

{ } Belvidere Physical Therapy
{ } Edgebrook Physical Therapy
{ } Marengo Physical Therapy
{ } McHenry County Physical Therapy
{ } Ogle County Physical Therapy
{ } Poplar Grove Physical Therapy
{ } Sauk Valley Physical Therapy

Patient Name: _____ _____ _____ DOB: ___/___/_____
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

What movement or activities increase your pain? (Circle all that apply)

Sitting greater than _____ minutes
Walking greater than_____ minutes
Standing greater than _____ minutes
Changing positions (i.e., sit to stand)
Light activity / light housework
Vigorous activity or exercise (run/weightlift/jump)
Sexual activity
Other, please list:_____
Coughing/sneezing/straining
Laughing/yelling
Lifting/bending
Cold weather
With triggers (i.e., running water, key in door)
Nervousness or anxiety
No activity affects the problem

Ob/Gyn History (Circle all that apply)

Childbirth vaginal deliveries #_____
Episiotomy #_____
C-section #_____
Difficulty childbirth #_____
Prolapse or organ "falling out":_____
Surgery:_____
Painful periods Y / N
Painful vaginal penetration Y / N
Pelvic pain Y / N
Vaginal dryness Y / N
Menopause/when:_____
Other/describe:_____

Bladder/Bowel Habits/Problems (Circle Y or N)

Trouble initiating urine stream Y / N
Urine intermittent/slow stream Y / N
Trouble emptying bladder Y / N
Trouble emptying bladder completely Y / N
Difficulty stopping the urine stream Y / N
Straining or pushing to empty bladder Y / N
Dribbling after urination Y / N
Constant urine leakage Y / N
Other/describe_____
Blood in urine Y / N
Painful urination Y / N
Trouble feeling bladder urge/fullness Y / N
Strong/abrupt urge to urinate 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

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Please answer the following questions about your general pelvic health:

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.
5. When you have an urge to have a bowel movement, how long can you delay before you have to use the toilet? _____minutes, _____hours, _____not at all.
6. If constipation is present describe management techniques: _____.
7. Average fluid intake (one glass is 8 oz or on cup) _____ glasses per day.
   Of this total how many glasses are caffeinated? _____ glasses per day.
8. Rate a feeling of organ prolapse (organ "falling out") 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

9. A. Bladder leakage-number of episodes
   ____No leakage
   ____Times per day
   ____Times per week
   ____Times per month
   ____Only with physical exertion/cough

   B. Bowel leakage-number of episodes
   ____No leakage
   ____Times per day
   ____Times per week
   ____Times per month
   ____Only with exertion/strong urge

10. A. On average, how much urine do you leak?
    ___No leakage
    ___Just a few drops
    ___Wets underwear
    ___Wets outerwear
    ___Wets the floor

    B. How much stool do you lose?
    ___No leakage
    ___Stool staining
    ___Small amount in underwear
    ___Complete emptying

11. What form of protection do you wear?
    ___None
    ___Minimal protection (tissue paper/paper towel/pantishields)
    ___Moderate protection (absorbent product, maxipad)
    ___Maximum protection (specialty product/diaper)
    On average, how many pad/protection changes are required in 24 hours? _____# of pads

Patient/ Guardian Signature: _____ Date: _____

Reviewed by therapist: _____ Date: _____