

Pelvic Floor History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please answer the following by making a √ in the appropriate box.

1. Main concern (circle one) leakage/prolapse/pain Other: \_\_\_\_\_
2. How long has the problem been going on:  
 1week-3mos  3-12mos  1-5yrs  5-10yrs  More than 10yrs  After surgery: type- \_\_\_\_\_
3. Did the leakage/pain:  Begin suddenly  Develop gradually over time
4. Have you ever seen an urologist or other doctor for your problem?  Yes  No  
 If yes, Name: \_\_\_\_\_  
 What did they do? Tests? \_\_\_\_\_
5. Have you previously tried pelvic muscle exercises or Kegel exercises?  Yes  No  
 If yes, describe how: \_\_\_\_\_
6. Are you avoiding certain activities because of this problem?  Yes  No
7. Have you tried other treatments/medications for your problem? Please explain:  
 \_\_\_\_\_

**Patients with URINARY CONCERNS OR PROLAPSE proceed with #8 through the rest of the form.  
Patients with PAIN skip to #20 through the rest of the form.**

8. Do you experience leakage during any of the following?  Without being aware  
 Coughing  Sneezing  Laughing  Walking  Active exercise  Lifting heavy objects  Rushing  
 Nervousness  Running water  Cold weather  Changing position  While sleeping  
 Continual leakage  "Key in the door"  On the way to the bathroom  Dribbling after urination
9. How often do you lose urine during a typical week?  Less than once a week  Once a week  
 More than once a week  Once a day  More than once a day
10. When does the leakage occur?  During the day  During the night  Both day and night
11. When you leak, how much do you leak?  
 None  Damp/few drops  Wet enough to wet underpants  Quite wet (soak pads or clothing)
12. How often do you urinate during the day?  
 More than every hour  Every 1-2 hours  Every 3-5 hours  Frequency varies  Unknown
13. Do you wake up at night to urinate?  Never or rarely  About 1-2 times  3 or more times
14. When your bladder feels full, how long can you hold your urine?  Less than 1-2 minutes  
 Just a few minutes  More than a few minutes  Cannot tell if bladder is full
15. Do you have strong urinary urges you cannot always control?  Yes  No
16. Do you have trouble getting to the toilet on time to urinate?  Yes  No
17. When urinating, do you experience any of the following:  Difficulty starting stream  Weak/slow stream,  
 dribbling  Pain  Discomfort  Burning  Blood in urine  Bladder not fully empty  
 Difficulty stopping stream  None of the above
18. Do you use any of the following for protection during leakage?  None  Panty liner  Sanitary  
 napkin/feminine hygiene pad  Minipad  Disposable protective underwear  Adult briefs/diapers  
 Guards for men  Bed or furniture pad  Bedside commode/urinal
19. How many times a day do you need to change pads/products?  1  2  3  4  5  6 or more
20. Are you sexually active now?  Yes  No
21. Do you have pain/discomfort with intercourse?  Yes  No  
 If yes, when? \_\_\_\_\_  
 If with entry, with partial or full entry? \_\_\_\_\_  
 If with thrusting, with some, deep or all thrusting? \_\_\_\_\_  
 Pain with ejaculation?  Yes  No      Pain after withdrawal?  Yes  No  
 Pain with post-coital urination?  Yes  No

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Please answer the following by making a √ in the appropriate box.

- 22. Do you ever leak/lose urine during intercourse?  Yes  No
- 23. How often do you have a bowel movement?  Once a day  More than once a day  2-3 times a day  
 1-2 times a week  Less than once a week
- 24. Do you have any of the following?  Constipation  Diarrhea  Bloody stool  None
- 25. How often do you strain to move your bowels?  Every time  Occasionally  Never  \_\_\_\_\_
- 26. Do you use laxatives?  Yes  No What? \_\_\_\_\_
- 27. Do you have pain with bowel movements?  Yes  No
- 28. Do you ever lose control of your bowels?  Yes  No How often? \_\_\_\_\_
- 29. Do you have severe urge to move your bowels?  Yes  No
- 30. Has there been a change in the pattern of your bowel movements in the past year?  Yes  No
- 31. What is the consistency of the bowels?  Pellet  Firm  Soft  Liquid
- 32. How often do you leak gas?  Multiple times a day  Once a day  2-3 times a week

**PAIN SCALE**

If you have pain/discomfort, rate it on a scale of 0-10 and circle below. (0=no pain, 10=worst pain imaginable)

Pain now: 0 1 2 3 4 5 6 7 8 9 10  
 Pain at its worst: 0 1 2 3 4 5 6 7 8 9 10  
 Pain at its least: 0 1 2 3 4 5 6 7 8 9 10

**PERCEIVED SEVERITY SCALE**

How significantly are your problems/concerns affecting your life currently?

(0=not an issue, 10=life-consuming/daily life revolves around it)  
 Please circle. 0 1 2 3 4 5 6 7 8 9 10

**MEN**

Have you ever had:  Prostatitis/BPH  Prostate cancer  Discharge from the genital area  
 Do you have difficulty keeping or getting an erection?  Yes  No  
 If yes, did your problem start with prostate cancer surgery?  Yes  No

**WOMEN**

Have you ever been diagnosed with the following:  Cystocele  Rectocele  Uterus prolapse  
 Have you had:  Hysterectomy, If yes, year: \_\_\_\_\_  Vaginal  Abdominal  Ovaries removed  
 Bladder suspension  Bladder tumor  Urethral stricture/dilation  Pelvic radiation  
 Discharge from the genital area  Itching/odor- genital area/vagina  
 Urinary tract infection, date: \_\_\_\_\_  Collagen injections, Date & number \_\_\_\_\_  
 Pregnancy and Childbirth: Are you currently pregnant?  Yes  No  
 \_\_\_\_\_ # of pregnancies, \_\_\_\_\_ # of vaginal births  
 \_\_\_\_\_ # of Cesarean sections, \_\_\_\_\_ # of Episiotomies  
 Have you ever used:  Pessary  IUD  Diaphragm  
 Birth control, please specify: \_\_\_\_\_

Indicate what amount of fluid you drink in a typical day:

\_\_\_\_\_oz. Water \_\_\_\_\_oz. Juice \_\_\_\_\_oz. Soda \_\_\_\_\_c. Coffee \_\_\_\_\_c. Tea \_\_\_\_\_Other  
 Do you drink alcohol?  Yes  No If yes, indicate glasses per week:  
 \_\_\_\_\_Beer (glasses) \_\_\_\_\_Wine (glasses) \_\_\_\_\_Spirits (oz.)  
 Do you smoke/use tobacco?  Yes  No If yes, indicate how many per day:  
 \_\_\_\_\_cigarettes \_\_\_\_\_cigars \_\_\_\_\_pipe \_\_\_\_\_chew tobacco \_\_\_\_\_recreational drugs

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Please answer the following by making a √ in the appropriate box.

Occupation (now or last job): \_\_\_\_\_

Are there cultural/religious practices that may affect your healthcare? \_\_\_\_\_

Date of last medical exam:  Within last month  Within last 6 months  More than 6 months

Have you ever been diagnosed or treated for cancer, a tumor, noticed any lumps or swelling?

Please describe: \_\_\_\_\_

Please check if you have been treated for, or diagnosed with, any of the following:

- Alzheimer's Disease/Dementia
- Anemia
- Arthritis
- Asthma
- Back Injuries/Compression fracture
- Bleeding problems
- Cancer
- Cataracts
- Chest pain
- Constipation/Impaction
- COPD
- Diabetes
- Other – specify \_\_\_\_\_
- Falls
- Fracture/Joint Replacement
- Glaucoma
- Head Injuries
- Heart disease (CAD, CHF, Arrhythmia, Atrial fibrillation)
- Hemorrhoids
- High blood pressure
- Irritable Bowel Syndrome
- Kidney stone/Bladder stone
- Mitral valve prolapse
- Multiple sclerosis
- Osteoporosis
- Pacemaker
- Parkinson's Disease
- Polyps
- Renal/Kidney Disease
- Seizures
- Sexually Transmitted Disease
- Skin condition
- Stroke
- Thyroid disorder
- Vascular Disease/PVD

Previous surgeries: \_\_\_\_\_

List all medications you are currently taking (prescription & over the counter).

Name	Dosage	Reason for Taking

List all allergies (medications, foods or other) & reactions: \_\_\_\_\_

Check if you have ever been treated for any of the following:

- Anxiety  Depression  Nervous problems  Alcoholism  Drug addiction

Do you have a history of sexual abuse?  Yes  No      Do you feel safe in your current relationship?  Yes  No

Check if you have any of the following:

- Feelings of tingling or numbness in any part(s) of your body
- Weakness of arms or legs
- Weakness of one side of your body

Check if you use any of the following:

- Wheelchair  Walker  Cane  None

By signing below, I demonstrate that I understand that evaluation and treatment of the pelvic floor MAY include EMG Biofeedback, rehabilitative ultrasound imaging, and/or an internal digital exam to better treat the pelvic floor muscles and fascial supports.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_\_