Name: ____ DOB ___________ Today's Date: __________

Pelvic Symptom Questionnaire

Please fill this form out even if you do not think these questions relate to you.

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining ______% of time
Y/N	Painful urination	Y/N	Current laxative use -type ____________
Y/N	Other/describe ____________________		

Describe typical position for emptying: ____

1. Frequency of urination: awake hour's ____ 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, or _______________.
5. The bowel movements typically are: watery ___ loose ___ formed___ pellets ___ other _______
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? ________minutes, _______hours, _________not at all.
7. If constipation is present describe management techniques _________________________________
8. Average fluid intake (one glass is 8 oz or one cup) ________ glasses per day.
   Of this total how many glasses are caffeinated?___ glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your menstrual period)
___With standing for ____________ minutes or _____________hours.
___With exertion or straining
___Other____

10a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other ______________________

12. What form of protection do you wear? (Please complete only one)

___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other ____

On average, how many pad/protection changes are required in 24 hours? _____# of pads

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Name: ______________________________________ DOB ___________ Today's Date: __________

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, check the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the following usually affect your	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
1. Ability to do household chores (cooking, laundry housecleaning)?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
3. Entertainment activities such as going to a movie or concert?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
5. Participating in social activities outside your home?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
6. Emotional health (nervousness, depression, etc)?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit
7. Feeling frustrated?	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit	□Not at all □Somewhat □Moderately □Quite a bit