Geoffrey **C**undiff **P**rofessional **M**edical **C**orporation

Centre for Pelvic Floor Competence

Follow-up Questionnaire

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

Reason for Today's Visit: (please describe the problem you are having)

_____

_____

Past Medical/Surgical History (Please describe any changes in your medical conditions or surgeries you have had since your last visit):

_____

_____

Medications: (Please list any new or changed medicines since your last visit including dose and how often you take them)

Name of Medicine	Dose	How often taken (per day)
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __
		□ once, □twice, □three times, □four times, Other __

Allergies: (list all allergies to medicines)

Name of Medicine	Reaction

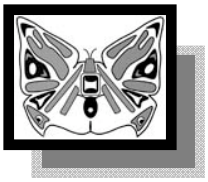
We are interested in how well the intervention that you had for pelvic floor symptoms has improved your symptoms and overall quality of life. Please indicate which intervention you had most recently:

□ Pessary □ Medication □ Physical Therapy □ Surgery

Please choose one response below to indicate your ***overall impression*** of your pelvic floor disorders since the intervention.

- □ Very much better
- □ Much better
- □ A little bit better
- □ No change
- □ A little bit worse
- □ Much worse
- □ Very much worse

Geoffrey **C**undiff **P**rofessional **M**edical **C**orporation



Centre for

Pelvic Floor

Competence

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

Follow-up Questionnaire

Bladder & Bowel Function (Please answer the next questions based on how your bladder and bowel Have been working since your last visit)

____How many times do you urinate during waking hours?
____How many times do you get up to urinate at night?
____ How many bowel movements you have per week?

Do you use pads for any of the following reasons besides menstrual flow?

- □ Urinary incontinence
- □ Fecal incontinence
- □ Other

If you use pads for incontinence, what type of pads do you use?

- □ None
- □ Minipad
- □ Shield
- □ Diaper

If you use pads for incontinence, how many per 24 hours?
____ Pads per day

Questions about your symptoms

Instructions:
The following questions ask about your pelvic organs. Please answer these questions by putting a **X** in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.**

1. Do you usually experience *pressure* in the lower abdomen? □ No; □ Yes **0**

   If yes, how much does this bother you?
   □ **1** □ **2** □ **3** □ **4**
   Not at All - Somewhat - Moderately - Quite a bit

2. Do you usually experience *heaviness or dullness* in the pelvic area? □ No; □ Yes **0**

   If yes, how much does this bother you?
   □ **1** □ **2** □ **3** □ **4**
   Not at All - Somewhat - Moderately - Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? □ No; □ Yes **0**

   If yes, how much does this bother you?
   □ **1** □ **2** □ **3** □ **4**
   Not at All - Somewhat - Moderately - Quite a bit

4. Do you usually have to push on the vagina or around the □ No; □ Yes

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

rectum to have or complete a bowel movement? **0**

If yes, how much does this bother you?
□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying? □ No; □ Yes
0

If yes, how much does this bother you?
□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? □ No; □ Yes
0

If yes, how much does this bother you?
□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement? □ No; □ Yes
0

If other than never, how much does this bother you?
□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?
If other than never, how much does this bother you? □ No; □ Yes
0

□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

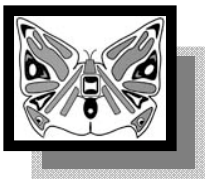
9. Do you usually lose stool beyond your control if your stool is well formed? □ No; □ Yes
0

If yes, how much does this bother you?
□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid? □ No; □ Yes
0

If yes, how much does this bother you?
□ **1** □ **2** □ **3** □ **4**
Not at All - Somewhat - Moderately - Quite a bit

11. Do you usually lose gas from the rectum beyond your control? □ No; □ Yes



Centre for

Pelvic Floor

Competence

Follow-up Questionnaire

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

0

If yes, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

12. Do you usually have pain when you pass your stool? □ No; □ Yes
0

If yes, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? □ No; □ Yes
0

If other than never, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? □ No; □ Yes
0

If yes, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

15. Do you usually experience frequent urination? □ No; □ Yes
0
If yes, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

16. Do you usually experience urine leakage associated with a feeling of urgency, that is a strong sensation of needing to go to the bathroom? □ No; □ Yes
0
If yes, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? □ No; □ Yes
0
If yes, how much does this bother you?

□ **1** □ **2** □ **3** □ **4**

Not at All - Somewhat - Moderately - Quite a bit

Geoffrey **C**undiff **P**rofessional **M**edical **C**orporation

Centre for

Pelvic Floor

Competence

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

Follow-up Questionnaire

18. Do you usually experience small amounts of urine leakage (that is, drops)? ☐ No; ☐ Yes **0**

If yes, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

19. Do you usually experience difficulty emptying your bladder? ☐ No; ☐ Yes **0**

If yes, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region? ☐ No; ☐ Yes **0**

If yes, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

The next section of the questionnaire pertains to sexual activity. Please answer the following questions in terms of your current experience **by circling the appropriate number**. Note: "*Sexual activity*" covers behaviors from self-stimulation (masturbation), foreplay (arousal with partner) to actual intercourse.

21. How enjoyable are sexual activities currently for you?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

22. How often during sex activities do you feel aroused or excited (heart beating fast/heavier breathing/vaginal wetness/flushing)?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

23. Do you currently experience orgasm (climax) during sex activity?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

24. Do you currently experience any lack of vaginal wetness (lubrication) during sex activities

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

25. Give an approximate estimate by circling the answer which best describes how many times you have had sexual thoughts or fantasies (e.g., daydreams) during the last month.

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Centre for

Pelvic Floor

Competence

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

Follow-up Questionnaire

Never - <1 per week – 1-2 times/ week – several/week – 1-2 times/day – several times/day

26. During the past month how often have you had sexual activities?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Never - <1 per week – 1-2 times/ week – several/week – 1-2 times/day – several times/day

27. Do you have a current sexual partner(s)? (please check)

☐ Yes ☐ No

The rest of the questions relate to sexual partners. If you have one or more sexual partners please continues the questionnaire below. If you have no current sexual partner you should go to page 10.

28. How many current sexual partners have you had in the past 6 months? _____

Please answer the following questions in relation to your main sexual partner.

29. How much passionate love do you feel for your partner?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

30. Are you satisfied with your partner(s) as a lover?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

31. Do you currently experience pain during intercourse?

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

32. Does your partner(s) experience difficulty in sexual performance? (e.g., erectile problems, ejaculation difficulties, low arousal)

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Not at All A Great Deal

Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how much your activities,

Geoffrey **C**undiff **P**rofessional **M**edical **C**orporation

Centre for

Pelvic Floor

Competence

Name
(last, first)_____
MSP#
_____
Date of Birth:
(mm/dd/yy) _____
Date of Visit:
(mm/dd/yy) _____

Follow-up Questionnaire

relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please be sure to mark an answer in **all 3 columns** for each question.

How do symptoms or conditions related to the following usually affect your ☐	**Bladder or *urine***	***Bowel or rectum***	***Vagina or Pelvis***
1. ability to do household chores (cooking, housecleaning, laundry)?	☐ 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

Thank You for taking the time to complete this questionnaire!