Centre for Pelvic Floor
Initial Evaluation Questionnaire

Your Contact Information
Address Click here to enter text.
Email: Click here to enter text.
Preferred Phone: Click here to enter text.
Your Referring Physician
Name Click here to enter text.
Address Click here to enter text.
Office Phone: Click here to enter text.

Name: Click here to enter text.

Date of Birth: Click here to enter text.

PHN: Click here to enter text.

Reason for Today's Visit: _____

Past Medical History (Please check any conditions which you have or for which you have been treated):

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Sjogrens
- ☐ High blood pressure
- ☐ Peripheral vascular disease
- ☐ Heart attack or angina
- ☐ Congestive heart failure
- ☐ Abnormal heart rate
- ☐ Stroke
- ☐ Emphysema
- ☐ Asthma
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Diabetes mellitus
- ☐ Indigestion
- ☐ Ulcer (stomach or intestinal)
- ☐ Hiatus hernia
- ☐ Constipation
- ☐ Liver disease
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Inflammatory bowel disease
- ☐ Chronic back pain (over 6 months)
- ☐ Back pain during one or more pregnancies
- ☐ Back pain in first 3 months after childbirth
- ☐ Scoliosis

Cancer
- ☐ Breast
- ☐ Colon
- ☐ Uterus
- ☐ Ovary
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Other cancer_____

Injuries (fall, fracture or motor vehicle accident)
- ☐ Head
- ☐ Neck (whiplash)
- ☐ Shoulder
- ☐ Chest/ribs
- ☐ Spine
- ☐ Pelvis
- ☐ Tailbone
- ☐ Groin
- ☐ Knee
- ☐ Ankle

- ☐ Alzheimer's Dementia
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Paralysis
- ☐ HIV/AIDS
- ☐ Other condition_____

Past Surgical History (Please check all surgeries that you have undergone)

- ☐ Brain surgery
- ☐ Heart surgery
- ☐ Appendectomy
- ☐ Breast biopsy/ lumpectomy/ mastectomy
- ☐ Breast plastic surgery
- ☐ Laparoscopy why
- ☐ Open abdominal surgery why _____
- ☐ Gall bladder removal
- ☐ Hernia repair where: _____
- ☐ Hip surgery
- ☐ Knee surgery
- ☐ Varicose vein surgery
- ☐ Stomach or intestinal surgery
- ☐ Back surgery
- ☐ Tonsillectomy
- ☐ Thyroid surgery
- ☐ Other surgery _____

Have you had any of the following gynecologic surgeries? (check all that apply)

- ☐ Dilation and curettage (D&C)
- ☐ Hysteroscopy (to look in uterus)
- ☐ Hysterectomy (removal of uterus)
  - □ Through the abdomen
  - □ Through the vagina
- ☐ Surgery on an ovary
- ☐ Surgery to remove ovaries
- ☐ Tubes tied (sterilization)
- ☐ Removal of tube
- ☐ Surgery for prolapse
  _____How many times?
- ☐ Surgery for urinary leakage
  _____How many times?

Past Obstetrical History (Please complete your obstetrical history)

_____Number of times pregnant

_____Number of ectopic (tubal) pregnancies

_____Number of miscarriages

_____Number of abortions

_____Number of vaginal deliveries

_____Number of vaginal deliveries with forceps or vacuum

☐ Prior episiotomy or vaginal tear? (check if yes)

☐ Prior delivery with tear into rectum? (check if yes)

_____Number of cesarean deliveries

Birth weight of your largest child
_____pounds

Past Gynecologic History (Please complete your gynecological history)

☐ ***Are you still having periods (menses)?***

Are your periods usually? (please pick one)

- ☐ Regular (about once per month)
- ☐ Too frequent
- ☐ Infrequent

Is your flow?(please pick one)

- ☐ Normal
- ☐ Light
- ☐ Heavy

Do you have menstrual cramps?

- ☐ minimal
- ☐ Normal
- ☐ Severe

☐ ***Have you stopped having periods?***

At what age? _____

Are you taking estrogen replacement therapy? (please pick one)

- ☐ None
- ☐ Continuous (same pill/pills every day)
- ☐ Cyclic

Centre for Pelvic Floor

Initial Evaluation Questionnaire

Sexually Transmitted Diseases

If yes, which one(s) _____

Pap Smears

Last Pap (mm/dd/yy)_____

- ☐ normal
- ☐ abnormal

Prior Paps

- ☐ normal in past
- ☐ abnormal in past
- ☐ Surgery for abnormal pap

Last Mammogram

(mm/dd/yy)_____

- ☐ normal
- ☐ abnormal

Prior Mammograms

- ☐ normal in past
- ☐ abnormal in past
- ☐ Surgery for abnormal

Colonoscopy

(mm/dd/yy)_____

- ☐ normal
- ☐ abnormal

Findings: _____

Medications: (Please list all medicines you take, whether prescribed or not. If you know, include 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 _____

Allergies: (list all allergies to medicines)

Name of Medicine	Reaction
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.

Family History (Does anyone in your family have any of the following? – if yes, indicate who)

- ☐ High blood pressure
- ☐ Heart disease (angina) or heart attack
- ☐ Stroke
- ☐ Diabetes mellitus
- ☐ Incontinence
- ☐ Prolapse

Cancer

- ☐ Breast
- ☐ Colon
- ☐ Uterine
- ☐ Ovarian

Social History

Occupation: _____

☐ Retired
☐ Past heavy (occupational) weight lifting of over 10 lbs per day
☐ Current consistent heavy lifting of over 10 lbs per day

Habits:

If you drink caffeinated drinks, _____Drinks/day

How many total cups of water per day
_____Drinks/day

Please describe your tobacco use

☐ Never
☐ Past
☐ Present

If you smoke cigarettes, please list the number of
_____Packs/day _____Years smoking

Please describe your alcohol use

☐ Never ☐ Past ☐ Present

If you drink alcohol, please list the number of
_____Drinks/week _____Years drinking

Please check any boxes that describe your race or ethnicity

☐ White/Caucasian
☐ Black/African
☐ Asian
☐ First Nations
☐ Hispanic
☐ Other

What is your marital status?

☐ Single
☐ Married
☐ Separated/Divorced
☐ Widowed

Did you finish?

☐ High school ☐ College ☐ Graduate School

How would you describe your job and lifestyle (please pick one)

☐Sedentary
☐Active
☐Strenuous
☐Unsure

Choose the maximum activity you can perform in day to day life: (please pick one)

☐ Participate in strenuous sports like swimming, singles tennis, football, basketball or skiing
☐ Participate in moderate recreational activities like golf, dancing, doubles tennis or throwing a baseball or football
☐ Do heavy work around the house like scrubbing floors or lifting/moving heavy furniture
☐ Run a short distance
☐ Walk on level ground at 4 mph
☐ Climb a flight of stairs or walk up a hill
☐ Do light work around the house like dusting or washing dishes
☐ Walk a block or two on level ground at 2-3 mph

- ☐ Walk indoors around the house
- ☐ Eating, dressing, bathing or using the toilet without help
- ☐ I cannot do any of the above

Review of Symptoms (Please check all symptoms that apply to you)

- ☐ fatigue (tiredness)
- ☐ weight loss
- ☐ weight gain
- ☐ fever
- ☐ breast mass
- ☐ breast discharge
- ☐ hearing problems
- ☐ can't lie flat without getting short of breath
- ☐ chest pain
- ☐ passing out (fainting)
- ☐ need antibiotics before dental work
- ☐ daily cough for over 6 months
- ☐ coughing up blood
- ☐ shortness of breath
- ☐ nausea
- ☐ vomiting
- ☐ loss of appetite
- ☐ bleeding from rectum
- ☐ difficulty swallowing
- ☐ blood in urine
- ☐ joint pain
- ☐ leg swelling
- ☐ frequent headache
- ☐ difficulty seeing
- ☐ difficulty talking
- ☐ seizures
- ☐ weakness
- ☐ daily neck pain for over 6 months
- ☐ daily back pain for over 6 months
- ☐ daily tailbone pain for over 6 months
- ☐ daily pelvic pain for over 6 months
- ☐ daily groin pain for over 6 months
- ☐ numbness, or pins and needles sensations
- ☐ abnormal bleeding
- ☐ low blood count (anemia)

Bladder & Bowel Function (Please answer the next questions based on how your bladder and bowel usually work)

_____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, how many per 24 hours?
_____Pads per day
Which one(s):

- ☐ Minipad
- ☐ Shield
- ☐ Diaper

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 rectum to have or complete 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

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 yes, 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?
☐ No; ☐ Yes
0

If yes, how much does this bother you?
☐**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
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 yes, 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

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

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, 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

The next section of the questionnaire pertains to sexual activity. Many pelvic floor disorders impact sexual function. Recognizing that these are personal questions, your response to any question is optional

1. Which of the following best describes you:

   Not sexually active at all ☐ Go to item Q2 (Section 1)
   Sexually active with or without a partner ☐ skip to item Q7 (Section2)

Section 1: For those who are NOT Sexually Active
If you engage in sexual activity please check this box ☐ and skip to item Q7 (Section2)

2. The following are a list of reasons why you might NOT be sexually active, for each one please indicate how strongly you agree or disagree with it as a reason that you are NOT sexually active.

	Strongly Agree	Somewhat agree	Somewhat disagree	Strongly disagree
a) No partner	☐(1)	☐(2)	☐(3)	☐(4)
b) No interest	☐(1)	☐(2)	☐(3)	☐(4)
c) Due to bladder or bowel problems (urinary or fecal incontinence) or due to prolapse (a feeling of or a bulge in the vaginal area)	☐(1)	☐(2)	☐(3)	☐(4)
d) Because of my other health problems	☐(1)	☐(2)	☐(3)	☐(4)
e) Pain	☐(1)	☐(2)	☐(3)	☐(4)

3. How much does the fear of leaking urine and/or stool and/or a bulging in the vagina (either the bladder, rectum or uterus falling out) cause you to avoid or restrict your sexual activity?
   ☐ (1) Not at all
   ☐ (2) A little
   ☐ (3) Some
   ☐ (4) A lot
4. For each of the following, please circle the number between 1 and 5 that best represents how you feel about your sex life. **RATING**

   a. Satisfied {1 2 3 4 5} Dissatisfied
   b. Adequate {1 2 3 4 5} Inadequate

5. How strongly do you agree or disagree with each of the following statements:

	Strongly Agree	Somewhat agree	Somewhat disagree	Strongly disagree
a) I feel frustrated by my sex life	☐(1)	☐(2)	☐(3)	☐(4)
b) I feel sexually inferior because of my incontinence and/or prolapse	☐(1)	☐(2)	☐(3)	☐(4)

c) I feel angry because of the impact that incontinence and/or prolapse has on my sex life	☐(1)	☐(2)	☐(3)	☐(4)

6. Overall, how bothersome is it to you that you are not sexually active?
   - ☐ (1) Not at all
   - ☐ (2) A little
   - ☐ (3) Some
   - ☐ (4) A lot

End of Items for Not Sexually Active

Section 2: For Those Who ARE Sexually Active

The remaining items in the survey are about a topic that one is not often asked to report on in a survey please answer as honestly and clearly as you possibly can.

7. How often do you feel sexually aroused (physically excited or turned on) during sexual activity?
   - ☐ (1) Never
   - ☐ (2) Rarely
   - ☐ (3) Sometimes
   - ☐ (4) Usually
   - ☐ (5) Always

8. When you are involved in sexual activity, how often do you feel each of the following:

	Never	Rarely	Sometimes	Usually	Almost Always
a)Fulfilled	☐(1)	☐(2)	☐(3)	☐(4)	☐(5)
b)Shame	☐(1)	☐(2)	☐(3)	☐(4)	☐(5)
c)Fear	☐(1)	☐(2)	☐(3)	☐(4)	☐(5)

9. How often do you leak urine and/or stool with <u>any type</u> of sexual activity?
   - ☐ (1) Never
   - ☐ (2) Rarely
   - ☐ (3) Sometimes
   - ☐ (4) Usually
   - ☐ (5) Always

10. Compared to orgasms you have had in the past, how intense are your orgasms now?
    - ☐ (1) Much less intense
    - ☐ (2) Less intense
    - ☐ (3) Same intensity
    - ☐ (4) More intense
    - ☐ (5) Much more intense

11. How often do you feel pain during sexual intercourse? (If you don't have intercourse check this box ☐ and skip to the next item.)

- ☐ (1) Never
- ☐ (2) Rarely
- ☐ (3) Sometimes
- ☐ (4) Usually
- ☐ (5) Always

12. Do you have a sexual partner?
    - ☐ (1) Yes → go to Q13
    - ☐ (2) No → Skip to Q15

13. How often does your partner have a problem (lack of arousal, desire, erection, etc.) that limits your sexual activity?
    - ☐ (1) All of the time
    - ☐ (2) Most of the time
    - ☐ (3) Some of the time
    - ☐ (4) Hardly ever/Rarely

14. In general, does your partner has a positive or negative impact on each of the following:

	Strongly Agree	Somewhat agree	Somewhat disagree	Strongly disagree
a) Your sexual desire	☐(1)	☐(2)	☐(3)	☐(4)
b) The frequency of your sexual activity	☐(1)	☐(2)	☐(3)	☐(4)

15. When you are involved in sexual activity, how often do you feel that you want more?
    - ☐ (1) Never
    - ☐ (2) Rarely
    - ☐ (3) Sometimes
    - ☐ (4) Usually
    - ☐ (5) Always

16. How frequently do you have sexual desire, this may include wanting to have sex, having sexual thoughts or fantasies, etc.?
    - ☐ (1) Daily
    - ☐ (2) Weekly
    - ☐ (3) Monthly
    - ☐ (4) Less often than once a Month
    - ☐ (5) Never

17. How would you rate your level (degree) of sexual desire or interest?
    - ☐ (1) Very high
    - ☐ (2) High
    - ☐ (3) Moderate
    - ☐ (4) Low
    - ☐ (5) Very low or none at all

18. How much does the fear of leaking urine, stool and/or a bulging in the vagina (prolapse) cause you to avoid sexual activity?
    - ☐ (1) Not at all
    - ☐ (2) A Little
    - ☐ (3) Some
    - ☐ (4) A Lot

19. For each of the following, please circle the number between 1 and 5 that best represents how you feel about you sex life.

	RATING					
a. Satisfied	1	2	3	4	5	Dissatisfied
b. Adequate	1	2	3	4	5	Inadequate
c. Confident	1	2	3	4	5	Not Confident

20. How strongly do you agree or disagree with each of the following statements:

	Strongly Agree	Somewhat agree	Somewhat disagree	Strongly disagree
a) I feel frustrated by my sex life	☐(1)	☐(2)	☐(3)	☐(4)
b) I feel sexually inferior because of my incontinence and or/prolapse	☐(1)	☐(2)	☐(3)	☐(4)
c) I feel embarrassed about my sex life	☐(1)	☐(2)	☐(3)	☐(4)
d) I feel angry because of the impact that incontinence and/or prolapse has on my sex life	☐(1)	☐(2)	☐(3)	☐(4)