Patient Name ______________________________

Date ______________________________

East Sacramento Physical Therapy
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Pelvic Symptom Questionnaire

Bladder

1. How many cups per day do you drink of water? ____ Caffeinated drinks?____ Alcohol (per week)?____
2. Number of times you urinate during the day?____ During the night?____ Time between voids?______
3. How urgent is your need to urinate typically? (Circle) Absent/ Small/ Medium/ Strong
4. When you have a normal urge to urinate, how long can you delay before you have to go? ________________
5. The usual amount of urine passed is: (Circle) Small/ Medium/ Large
6. Do you lose urine when you: (Check all that apply)
   __ Cough/ Sneeze/ Laugh __ Hear running water __Exercise/ Run __Feel cold
   __ On the way to the restroom __ Lift __Jump __During intercourse
   __ Other ______________________________
7. If there is urine leakage, how often? Times per day: ________________Times per night: ______________
8. On average, how much urine do you leak? (Circle) A few drops/ Wets underwear/ Wets outerwear/ Wets floor
9. Do you experience any of the following? Check all that apply:
   __Painful urination/ burning __Trouble feeling bladder urge __Intermittent/ slow urination
   __ Difficulty starting urine stream __ Dribbling after urination __Constant urine leakage
   __Strain or push to empty bladder __Recurrent bladder infections __ Blood in urine
   __Unable to empty bladder fully __Other, please list ______________________________
   __"Falling out" feeling/ prolapse
10. Leakage protection used? (Circle) None/ Liner/ Mini Pad/ Adult Pad/ Diaper _____ # in 24 hours

Bowel

1. Frequency of bowel movements during the day? _________ During the night? ____________
2. The bowel movements are typically: (circle) Liquid/ Soft/ Firm/ Pellets/ Other ____________________
3. Do you experience any of the following? Check all that apply:
   __ Strain to have a bowel movement __Pain with bowel movements __ Blood in stool/feces
   __ Include fiber in your diet __Frequent diarrhea __Constipation ____% of the time
   __Take laxatives/ enema regularly __Other, please list ______________________________
   __Strong urge to move bowels If urge, how long can you delay? ______________________________
4. If stool leakage, how much? Stool staining/small amount/ Complete emptying How often? ___________

Sexual Activity

1. Do you experience any of the following? Check all that apply:
   __ Unable to tolerate manual sex __Unable to orgasm __ Painful periods
   __ Unable to tolerate oral sex __Pain with penetration __Erectile dysfunction
   __Vaginal dryness __Pain after sex __Painful ejaculation
2. Do you have a history of pain free intercourse in the past? ______________________________