Patient Name: ______________________________
DOB:______/_______/_________ Age:________

EAST SACRAMENTO PHYSICAL THERAPY

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PELVIC SYMPTOM QUESTIONNAIRE

Bladder

1. Average fluid intake (one glass in 8 0z., or one cup): _______ glasses per day. Of this total, how many glasses are caffeinated? _______ glasses per day. Type of caffeinated beverages: __________
2. Frequency of urination: Awake hours _____ times per day Sleep hours _____ times per night
3. How urgent is your need to go to the restroom: _____ minimal _____ moderate ____excessive
4. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet?
   ____ minutes ____ hours ____ not able to delay
5. The usual amount of urine passed is: _____ small _____ medium _____large

Y / N Trouble initiating urine stream	Y / N Urinary intermittent/slow stream	Y / N Strain or push to empty bladder
Y / N Difficulty stopping urine stream	Y / N Trouble emptying bladder completely	Y / N Blood in urine
Y / N Dribbling after urination	Y / N Constant urine leakage	Y / N Trouble feeling bladder urge
Y / N Recurrent bladder infections	Y / N Painful urination/ burning	Y / N Have "falling out" feeling

Y / N Other, please describe: ____________________ Describe typical position for emptying: ______________________

6. Bladder leakage _number of episodes
   _____ No leakage
   _____Times per day
   _____ Times per week
   _____Times per month
   _____ Only with physical exertion/cough

6b. On average, how much urine do you leak?
_____ No leakage
_____ Just a few drops
_____ Wets underwear
_____ Wets outerwear
_____ Wets the floor

Rate a feeling of an organ "falling out"/prolapsed or pelvic heaviness/pressure:

_____ None present
_____ Times per month (specify if related to activity or menstrual period)
_____ With standing for ___ minutes or ___ hours
_____ With exertion or straining
_____ Other: ______________________________

Protection: What form of protection do you wear? (Please select only one)

_____ None
_____ Minimal Protection (tissue paper/ panitshield)
_____ Moderate Protection (absorbent product maxi pad)
_____ Maximum Protection (specialty product/diaper)
_____ Other: ______________________________

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

Bowel

1. Frequency of bowel movements: _____ times per day _____ times per week Other: __________
2. The bowel movements are typically: ___ watery ___ loose ___ formed ___ pellets ___ other: ____
3. If constipation is present, describe management techniques: ______________________________
4. When you have an urge to have a bowel movement, how long can you delay before going to toilet?
5. _____ minutes _____hours _____not at all

Y / N Blood in stool/feces	Y / N Painful bowel movements (BM)	Y / N Trouble feeling bowel urge/fullness
Y / N Seepage/loss of BM without awareness	Y / N Trouble controlling bowel urges	Y / N Trouble holding back gas/feces
Y / N Trouble emptying bowel completely	Y / N Need to touch to complete BM	Y / N Staining of underwear after BM
Y / N Constipation/straining ___% of the time	Y / N Current laxative use – type	Y / N Other, please describe:

Describe typical position for emptying: ____

6. Bowel leakage – number of episodes
   _____No leakage
   _____Times per day
   _____Times per week
   _____Times per month
   _____Only with physical exertion

5b. How much stool do you lose?
_____No leakage
_____Stool staining
_____Small amount in underwear
_____ Complete emptying
_____Other: ________________________