Patient Name:______________________________
DOB:_____________________Age:____________
Date:______________________________________

EAST SACRAMENTO PHYSICAL THERAPY
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PELVIC SYMPTOM QUESTIONNAIRE

Bladder - Bowel Habits - Symptoms:

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/fullness
Y / N Recurrent bladder infections
Y / N Painful urination

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 support/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:____

1. Frequency of urination: Awake hours ____ 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 able to delay
3. The usual amount of urine passed is: ___ small ___ medium ___large
4. Frequency of bowel movements: ___ times per day ___ times per week Other:________________
5. The bowel movements are typically: ___ 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 an organ "falling out"/prolapsed 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 physical exertion/cough

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 select only one)
______ None
______ Minimal protection (tissue paper/paper towel/pantishield)
______ 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