Pelvic Floor Therapy Questionnaire

Patient Name _____ Date _____

Please fill in the following questionnaire to the best of your ability. The therapist will review the answers with you at your appointment.

History

Number of pregnancies _____
Number of vaginal deliveries _____
Birth weight of largest baby _____
Number of cesarean deliveries _____
Number of episiotomies _____
Did you have any trouble healing after delivery Y N
Do you have a history of sexual abuse or trauma Y N
Are you having regular periods/ menstrual cycles Y N
Do you have frequent urinary tract infections Y N
Please list any abdominal or pelvic surgeries:
_____
_____
Are you pregnant or attempting pregnancy Y N
Do you have a history of or current sexually transmitted disease Y N
If yes, please explain: _____
Date of last pelvic exam _____
Date of last urinalysis _____

Pain

Do you have pain with:
Sexual intercourse Y N
Pelvic exam Y N
Tampon use Y N
Back, leg, groin, abdominal pain Y N

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Bladder symptoms

Do you lose urine when you:
Cough/ sneeze/ laugh Y N
Lift/ exercise/ dance/ jump Y N
On the way to the bathroom Y N
Have a strong urge to urinate Y N
Hear running water Y N
Other _____ Y N

Do you wet the bed Y N
Have burning/ pain with urination Y N
Difficulty starting a stream of urine Y N
Strain to empty your bladder Y N
Feel unable to empty bladder fully Y N
Have a falling out feeling Y N
Have pain with a full bladder Y N
Have an urgency of urination (a strong urge to urinate) Y N
Urinate more than 7 times/day Y N
Wear pads Y N (If yes, how many during the day _____ , night _____)
What is your average daily fluid intake? Number of 8 oz. glasses per day_____; Number of caffeinated beverages _____

Bowel symptoms

Strain to have a bowel movement Y N
Leak / stain feces Y N
Include fiber in your diet Y N
Have diarrhea often Y N
Take laxatives / enema regularly Y N
Leak gas by accident Y N
Have pain with bowel movement Y N
Have a very strong urge to move your bowels Y N
How often do you move your bowels: _____ per day, week