



**PELVIC FLOOR
HEALTH PROGRAM**

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Pelvic Floor Health Program

As a new patient we ask that you review and complete this questionnaire so that we can understand your health history. Please complete **all** forms prior to your appointment including the voiding diary. You may fax it to us at (503) 418-4602, attention Luanna Smith, so that we can review it prior to your arrival, or bring it with you on the day of your appointment. We look forward to meeting you.

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Who Sent You Here?

Primary Doctor or Nurse

Yes, Please send my
primary care physician
a report as well.

For what condition(s) are you seeking treatment? (Check all that apply):

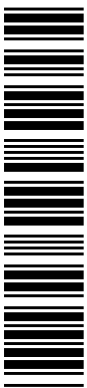
- Urinary incontinence (loss of bladder control)
- Urinary urgency
- Too frequent voiding/urinating
- Pelvic prolapse (bulge or protrusion in the vagina)
- Constipation or difficulties with bowel movements
- Anal incontinence (problem with bowel control)
- Pelvic pain
- Bladder pain
- Other (specify below) _____

What would you be willing to do to improve your condition? (Check all that apply)

- Lose weight
- Stop smoking
- Physical therapy/exercise for the pelvic floor muscles
- Diet/lifestyle modification
- Take medication
- Have surgery
- Conservative management (combination of treatments to specifically avoid surgery)

How motivated are you to take part in treatment or therapy?

- Not at all Somewhat Very Extremely



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24 HOUR VOIDING DIARY

Please complete this chart prior to your visit. Choose a 24-hour period when it is convenient for you to measure and record the following:

1. The amount of fluid you drink and type of beverage.
2. The amount of fluid you void (urinate). Use an old measuring cup or mark off ounces on an old jar or can and use that to measure. 2 tablespoons = 1 ounce.
3. The time when leakage occurred and whether or not you have an urge to void just prior to any leakage episodes.
4. The activity you are doing when you leak or feel the need to void.
5. Your awakening and bedtimes during that 24-hour period.

Below is a sample diary for your review.

Time	Fluid Intake Amount (oz)	Void Amount (oz)	Leaks or Accidents?	Strong urge to urinate?	Activity when you leaked or had an urge.
6:20 am		8 oz			Awakening
7:00 am	8 oz coffee				
7:20 am		6 oz	yes	yes	Washing
7:30 am	8 oz coffee				
8:00 am		8 oz			
8:45 am			yes	no	Coughing



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ALLERGIES

List any medications to which you are allergic and your reaction:

MEDICATIONS

What medicines are you currently taking? (Please include all over the counter medicines, herbs, remedies and supplements)

Medicine

Dose & time of day

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is your preferred pharmacy? _____

Have you ever used any of the following medicines to help control your bowels or bladder?

- Hyoscyamine (Cystospas/levsin)
- Detrol (Tolteridine)
- Ditropan (oxybutinin)
- Enablex (Darifenacin)
- Vesicare
- Sanctura
- Amitriptyline/Nortryptiline
- Cymbalta
- Pyridium
- Fiber Supplements (Metamucil, Fibercon, Benefiber, Citrucel, Psyllium, Konsyl)
- Stool Softeners (Colace)
- Laxatives (Senokot, Milk of Magnesia, Correctol, Ex-Lax, Miralax, Perdiem, Dulcolax, Lactulose)
- Antidiarrheals: (Lomotil, Immodium)
- Lotronex (Alosetron)
- Other: _____



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CURRENT SYMPTOMS

CURRENTLY are you having problems with: (circle)

General:	fevers/chills/decreased energy/weight loss/weight gain
Eyes:	visual disturbances/ dry eyes
Ears, nose, throat:	sinus problems/chronic colds/headache
Cardiovascular:	high blood pressure/palpitations/chest pain/swelling in legs
Respiratory:	shortness of breath/chronic cough
Gastrointestinal:	diarrhea/constipation/heartburn/bleeding
Genitourinary:	pain with urination/blood in urine
Musculoskeletal:	joint/back pain/arthritis
Emotional:	depression/anxiety/mental changes/emotional changes
Endocrine:	excessive thirst/hot spells or difficulty staying warm
Hematological:	excessive bruising/bleeding

MEDICAL HISTORY

Check any medical conditions you have ever been diagnosed with:

Immune system	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Immune Deficiency	
Circulatory	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Problem	<input type="checkbox"/> Low Platelets
	<input type="checkbox"/> Blood Clots		
Cancer	Type _____		
Cardiovascular	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Failure
	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Atrial fibrillation
Dermatology	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Rash	<input type="checkbox"/> Pilonidal Cyst
Endocrine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems	
Ear /Nose /Throat	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Vertigo	
GI	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Diverticulitis
	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Crohns' disease	<input type="checkbox"/> Heartburn
	<input type="checkbox"/> Hemorrhoids		
Gynecology	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian Cyst
Infectious Diseases	<input type="checkbox"/> HIV	<input type="checkbox"/> Herpes Zoster	
Kidney and Bladder	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Incontinence
	<input type="checkbox"/> Recurrent UTI	<input type="checkbox"/> Kidney Stones	
Mental Health	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Disease	<input type="checkbox"/> Schizophrenia
Musculoskeletal	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hip fracture
	<input type="checkbox"/> Fibromyalgia		
Neurology	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Myasthenia Gravis
Eye Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataracts	
Respiratory	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Emphysema	<input type="checkbox"/> COPD	<input type="checkbox"/> Long-Term Steroid Use

Please list any other medical problems you have:



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SURGICAL HISTORY

<u>Have you ever had...</u>	<u>No</u>	<u>Don't know</u>	<u>Yes</u>	<u>Was the incision Abdominal, Vaginal, or Laparoscopic?</u>
Hysterectomy? (removal of the uterus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Removal of your ovaries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery for prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mesh or graft placed for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

List all other surgeries and the approximate date:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Please note if you have a family history of any of these diseases:

Family Member(s):

- Problems with Anesthesia _____
- Asthma _____
- Circulatory (blood clots, anemia, bleeding problems) _____
- Cancer _____
- Diabetes _____
- GI (Stomach/Intestines) _____
- Heart Attack or Stroke _____
- High Blood Pressure _____



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OBSTETRIC/GYNECOLOGY HISTORY

Number of pregnancies _____
 Number of children born _____
 Number of vaginal deliveries _____
 Number of cesarean sections _____
 Weight of largest infant: _____
 Were forceps or a vacuum ever used? yes no don't know
 Did you ever require stitches? yes no don't know
 Have you experienced menopause? yes no don't know
 If yes, are you taking hormone replacement? yes no
 If no: _____
 Date of last menstrual period _____
 Date of last pap smear _____ Was it normal? yes no don't know
 Have you ever had an abnormal pap smear? yes no don't know
 Date of last colonoscopy _____ Was it normal? yes no don't know

LIFESTYLE

Do you currently smoke? yes no
 Have you ever smoked? yes no
 Starting at what age? _____
 Ending at what age? _____ How many packs a day? _____
 How many glasses of beer, wine, or alcohol do you drink per day? _____
 What kind of work do you do? _____
 Who is your main support person (partner, spouse, friend)? _____

Please check one or more choices from this list of racial backgrounds:

- American Indian/Alaska native Asian African American
 Native Hawaiian/Pacific Islander White Other _____

Which ONE do you consider to be your primary racial background? _____

Do you consider your ethnicity to be Hispanic or Latino? yes no

For office use only

Premenopausal: reg cycles postmenopausal: on E on E+P local HRT no HRT
 perimenopausal: irreg cycles Length of time on HRT: _____



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Many of our patients come to see us for concerns about the bladder and bowels, or bulging from the vagina or rectum. We ask that you please respond to the following questions.

Do you perform Kegel exercises? yes no not regularly
If yes, how frequently? _____ times per _____

How many times do you wake up at night to urinate? _____

Do you have difficulty starting urination? No Yes

Do you have to strain to urinate? No Yes

Is your urine flow weak? No Yes

Do you leak *immediately* after emptying your bladder (when you walk away from the toilet)? No Yes

Do you ever see blood in your urine? No Yes

Do you get frequent bladder infections? No Yes

How often do you experience urinary leakage?
 Less than once a month A few times a month
 A few times a week Every day and/or night

How much urine do you lose each time?
 Drops Small splashes More

Do you use pads for your leakage?
If yes, what kind? (circle one) pantyliner menstrual pad incontinence pad
How many per day? _____
Do you use pads for: (circle one) urinary leakage stool leakage both

How many bowel movements do you have? _____ per day _____ per week

BOWEL SYMPTOMS

For each of the following, please indicate on average how often **IN THE PAST MONTH** you experienced any amount of accidental bowel leakage: (Check only one box per row)

	2 or More Times a Day	Once a Day	2 or More Times a Week	Once a week	1 to 3 Times a Month	Never
Gas						
Mucus						
Liquid Stool						
Solid Stool						



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We ask that you please respond to the following questions by placing an "x" in the appropriate box. Each question tries to uncover specific aspects of these problems and how much it may bother you.

Problem	Does it affect you?	If yes, how much does it bother you?
1. Do you usually experience pressure in the lower abdomen?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
2. Do you usually experience heaviness or dullness in the pelvic area?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
5. Do you usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> 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?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
7. Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
9. Do you usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
11. Do you usually lose gas from the rectum beyond your control?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit



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<i>Problem</i>	<i>Does it affect you?</i>	<i>If yes, how much does it bother you?</i>
12. Do you usually have pain when you pass your stool?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
15. Do you usually experience frequent urination?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
16. Do you usually experience urine leakage associated with a feeling of urgency, (a strong sensation of needing to go to the bathroom)?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
17. Do you usually experience urine leakage related to coughing, sneezing or laughing?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
18. Do you experience small amounts of urine leakage (that is, drops)?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
19. Do you usually experience difficulty emptying your bladder?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit



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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.

<i>How do symptoms or conditions related to the following usually affect you?</i>	<i>Bladder or Urine</i>	<i>Bowel or Rectum</i>	<i>Vagina or Pelvis</i>
1. Ability to do household chores?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
3. Entertainment activities such as going to a movie or concert?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
5. Participating in social activities outside your home?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
6. Emotional health (nervousness, depression, etc.)?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit
7. Feeling frustrated?	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit	<input type="checkbox"/> not at all <input type="checkbox"/> somewhat <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit



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BIRTHDATE

YOUR SEXUALITY

The following is a list of questions about you and your partner's sex life. All information is strictly confidential. Please check the box that best answers the question for you. When answering the following questions, please consider your sexuality **over the past 6 months**.

If you are not sexually active, please mark the reason that best explains why:

- Low libido (desire) No partner My pelvic condition
 Partner is not able Personal choice Other

If you **ARE NOT** sexually active, **skip** to question 13. If you **ARE** sexually active, **complete** all that apply.

	Never	Less than 1x/month	Monthly	Weekly	Daily
1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Seldom	Some Times	Usually	Always
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel sexually excited (turned on) when engaging in sexual activity with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with the variety of sexual activities in your current sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel pain during sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you incontinent of urine (leak urine) with sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your partner have a problem with erections that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Patient Identification

	Much less intense	Less intense	Same intensity	More intense	Much more intense
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been raped or forced to engage in sexual activity against your will?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
14. Have you been hit, punched or otherwise hurt by someone within the past year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
15. Do you feel unsafe in your current relationship		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
16. Is there a partner from a previous relationship who is making you feel unsafe now?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Thank you for completing all pages. We look forward to meeting you.