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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, so that we can review it prior to your arrival, or bring it with you on the day of your appointment. Please note all your answers will be kept strictly confidential. We look forward to meeting you.

Today's Date: _____

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

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

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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?

- ❑ Amitriptyline
- ❑ Nortryptiline
- ❑ Enablex
- ❑ Darifenacin
- ❑ 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)
- ❑ Cymbalta
- ❑ Hyoscyamine (Cystospas/Levsin)
- ❑ Detrol (Tolteridine)
- ❑ Ditropan (oxybutynin)
- ❑ Vesicare
- ❑ Sanctura
- ❑ Tegaserod
- ❑ Other:_____

Have you ever had	**No**	**Don't know**	**Yes**	**Was the incision Abdominal, Vaginal, or Laparoscopic?**
Hysterectomy? (removal of the uterus)	❑	❑	❑	_____
Removal of your ovaries?	❑	❑	❑	_____
Bladder surgery?	❑	❑	❑	_____
Rectal surgery?	❑	❑	❑	_____
Surgery for prolapse?	❑	❑	❑	_____
Mesh or graft placed for any reason?	❑	❑	❑	_____

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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/ glaucoma/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/asthma
Gastrointestinal:	diarrhea/constipation/heartburn/bleeding/hepatitis
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/blood clots in veins/anemia

MEDICAL HISTORY

Check any medical conditions you have ever been diagnosed with:

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

Please list any other medical problems you have:

_____

_____

_____

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SURGICAL HISTORY

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 (mother, father, etc):

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

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
Have you ever been raped or forced to engage in sexual activity against your will? ❑ yes ❑ no
Have you been hit, punched or otherwise hurt by someone within the past year? ❑ yes ❑ no
Do you feel unsafe in your current relationship? ❑ yes ❑ no
Is there a partner from a previous relationship who is making you feel unsafe now? ❑ yes ❑ no

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)?

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PELVIC SYMPTOMS

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

Do you experience urinary leakage? ❑ No ❑ Yes

If 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

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?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
2. Do you usually experience heaviness or dullness in the pelvic area?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
5. Do you usually experience a feeling of incomplete bladder emptying?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ 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?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
7. Do you feel you need to strain too hard to have a bowel movement?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
9. Do you usually lose stool beyond your control if your stool is well formed?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
11. Do you usually lose gas from the rectum beyond your control?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
12. Do you usually have pain when you pass your stool?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit

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?***
15. Do you usually experience frequent urination?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ 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)?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
17. Do you usually experience urine leakage related to coughing, sneezing or laughing?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
18. Do you experience small amounts of urine leakage (that is, drops)?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
19. Do you usually experience difficulty emptying your bladder?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ quite a bit
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	❑ yes ❑ no	❑ not at all ❑ somewhat ❑ moderately ❑ 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 activity, 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.

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

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** 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.	❑	❑	❑	❑	❑
	Never	**Seldom**	**Some Times**	**Usually**	**Always**
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	❑	❑	❑	❑	❑
3. Do you feel sexually excited (turned on) when engaging in sexual activity with your partner?	❑	❑	❑	❑	❑
4. How satisfied are you with the variety of sexual activities in your current sex life?	❑	❑	❑	❑	❑
5. Do you feel pain during sexual intercourse?	❑	❑	❑	❑	❑
6. Are you incontinent of urine (leak urine) with sexual activity?	❑	❑	❑	❑	❑
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	❑	❑	❑	❑	❑
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?	❑	❑	❑	❑	❑
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	❑	❑	❑	❑	❑
10. Does your partner have a problem with erections that affects your sexual activity?	❑	❑	❑	❑	❑
11.Does your partner have a problem with premature ejaculation that affects your sexual activity?	❑	❑	❑	❑	❑
	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?	❑	❑	❑	❑	❑

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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. There are also "hats" for the toilet available at the Center for Women's Health.
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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24 HOUR VOIDING DIARY

Date: _____ Awakening time: _____ Bedtime: _____
Estimate how much fluid you consume in a day: _____

Time	Fluid Intake Amount (oz)	Void Amount (oz)	Leaks or Accidents?	Strong urge to urinate?	Activity when you leaked or had an urge.
TOTAL	**oz**	**oz**			