Tripler Army Medical Center
Department of Obstetrics and Gynecology
Division of Female Pelvic Medicine & Reconstructive Surgery

NAME:
HX #:
DATE OF BIRTH:
DATE:

PELVIC FLOOR DYSFUNCTION QUESTIONNAIRE

URINARY SYMPTOMS

Do you experience frequent urination?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you experience a strong feeling of urgency to empty your bladder?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you experience nighttime urination?

none ☐ minimally ☐ moderately ☐ severely ☐

How many times do you awaken to urinate during a typical night?

Do you experience bedwetting?

none ☐ minimally ☐ moderately ☐ severely ☐

Urinary Incontinence

Do you leak urine?

none ☐ minimally ☐ moderately ☐ severely ☐

If yes:

Does this interfere with your normal activities?

none ☐ minimally ☐ moderately ☐ severely ☐

How long have you had urinary incontinence?_____ months/years

Is your incontinence getting worse?

none ☐ minimally ☐ moderately ☐ severely ☐

For how long?_____months/years

Do you tie your incontinence to any of the following?

childhood ☐ pregnancy ☐ delivery ☐ medication ☐ surgery ☐ menopause ☐

Please mark any of the following boxes that describe the circumstances associated with your incontinence.

Stress Incontinence		**Urge Incontinence**		**Unconscious Incontinence**	
cough/sneeze		stand up		without stress or urge	
bend/stand		running water		continuous leak	
Lift		bathroom door		unaware of leak	
Exercise		riding in car		bedwetting	
Walk		sexual intercourse			

Referring to the above table, indicate what percentage of your incontinence occurs with each category.

Stress Incontinence	
Urge Incontinence	
Unconscious Incontinence	

How many times to you leak in an average week?

NAME:
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DATE OF BIRTH:
DATE:

Do you wear protection for your incontinence? yes ☐ no ☐

If yes:

Do you wear them during the; day ☐ night ☐ both ☐

Please indicate which type of protection you use and how many you use in a typical week.

Use	Product	Number per week
	mini-pad	
	panty liner	
	maxi-pad	
	adult diaper	

Please indicate if you have tried any of the following therapies for your incontinence.

General		Medications		Surgery	
Pelvic muscle exercises		Ditropan (oxybutinin)		Vaginal surgery	
Retraining drills		Tofranil (imipramine)		Abdominal surgery	
Biofeedback		Detrol (tolterodine)		Sling surgery	
Electrical stimulation		Other		Other	

Please estimate how much of the following beverages you drink each day.

cup = 8oz pint = 16oz quart = 32oz soda can = 12oz

Type of Beverage	Amount (oz)
Caffeinated	
Non-caffeinated	
Alcoholic	

Voiding Dysfunction

Do you experience difficulty emptying your bladder?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you have difficulty initiating flow?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you have a weak or prolonged flow?

none ☐ minimally ☐ moderately ☐ severely ☐

How often do you have intermittent flow?

none ☐ minimally ☐ moderately ☐ severely ☐

How often do you have a sense that you do not completely empty your bladder?

none ☐ minimally ☐ moderately ☐ severely ☐

How often do you have pain during urination?

none ☐ minimally ☐ moderately ☐ severely ☐

How often do you have to change position to completely empty your bladder?

none ☐ minimally ☐ moderately ☐ severely ☐

How often do you have dribbling after you have finished urinating?

none ☐ minimally ☐ moderately ☐ severely ☐

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Do you have problems with urinary tract infections?

none ☐ minimally ☐ moderately ☐ severely ☐

How many urinary tract infections have you had in your lifetime?

How many urinary tract infections have you had this year?_____ Date of last infection

PROLAPSE SYMPTOMS

Do you experience lower abdominal pressure?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you experience heaviness in the pelvic area?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you experience bulging or protrusion you can see in the vaginal area?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you experience pelvic discomfort when standing or physically exerting yourself?

none ☐ minimally ☐ moderately ☐ severely ☐

Please indicate if you have tried any of the following therapies for your prolapse.

General			**Surgery**	
Pelvic muscle exercises			Vaginal surgery	
Pessary			Abdominal surgery	
Other			Combined surgery	

BOWEL SYMPTOMS

How many bowel movements do you typically have per week_____per month

Please indicate if you have been diagnosed with any of the following:

Irritable bowel syndrome		Crohns disease	
Diverticulosis		Ulcerative colitis	
Diverticulitis		Levator spasm	
Hemorrhoids		Colonic inertia	

How often are you bothered by **diarrhea**?

none ☐ minimally ☐ moderately ☐ severely ☐

Anal Incontinence

Do you leak stool?

none ☐ minimally ☐ moderately ☐ severely ☐

If yes:

Do you leak liquid stool?

none ☐ minimally ☐ moderately ☐ severely ☐

Do you leak stolid stool?

none ☐ minimally ☐ moderately ☐ severely ☐

Does this interfere with your normal activities?

none ☐ minimally ☐ moderately ☐ severely ☐

NAME:
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How long have you had anal incontinence?
months/years
Is your incontinence getting worse?
none ☐ minimally ☐ moderately ☐ severely ☐
For how long?_____months/years
Do you tie your anal incontinence to any of the following?
childhood ☐ pregnancy ☐ delivery ☐ medication ☐ surgery ☐ menopause ☐
How many times to you leak in an average week?

Defecatory Dysfunction
How often are you bothered by **constipation**?
Never ☐ less than 25% of time ☐ less than 50% of time ☐ less than 75% of time ☐ 100% of time ☐

How many years have you suffered from constipation?
None ☐ 1 - 5 ☐ 5 - 10 ☐ 10 - 20 ☐ > 20 ☐

How often do suffer from pain during bowel movement?
Never ☐ less than 25% of time ☐ less than 50% of time ☐ less than 75% of time ☐ 100% of time ☐

How often do you feel that you have not completely evacuated your bowel after a bowel movement?
Never ☐ less than 25% of time ☐ less than 50% of time ☐ less than 75% of time ☐ 100% of time ☐

Do you ever use a finger to push in your vagina or on your bottom to help evacuation?
Never ☐ less than 25% of time ☐ less than 50% of time ☐ less than 75% of time ☐ 100% of time ☐

Do you ever use a finger in your anus to help evacuation?
Never ☐ less than 25% of time ☐ less than 50% of time ☐ less than 75% of time ☐ 100% of time ☐

How many minutes do you typically spend in the bathroom for a bowel movement?
<5 ☐ 5-10 ☐ 10-20 ☐ 20-30 ☐ >30 ☐

How many unsuccessful attempts at bowel movement do you have in 24 hours?
None ☐ 1 - 3 ☐ 3 - 6 ☐ 6 - 9 ☐ >9 ☐

Please indicate products that you have tried to improve your bowel function.

Metamucil (psyliium)			Milk of Magnesia (magnesium hydroxide)	
Citrucel (methylcelluose)			Ex-Lax (phenolphthalein)	
Colace (docusate sodium)			Dulcolax (bisacodyl)	
Surfak (docusate calcium)			Chronulac (lactulose)	
Peri-colace (docusate/casanthronol)			GoLytely (polyethelene glycol)	
Fleet's enemas			Senna (Senokot)	
Magnesium citrate			Other -	

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PELVIC FLOOR DYSFUNCTION QUESTIONNAIRE

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PELVIC PAIN

Do you have pelvic pain?

none ☐ minimally ☐ moderately ☐ severely ☐

If yes:

Does this interfere with your normal activities?

none ☐ minimally ☐ moderately ☐ severely ☐

How long have you had pelvic pain?_____ months/years

Is it getting worse?

none ☐ minimally ☐ moderately ☐ severely ☐

For how long?_____months/years

Do you tie your pelvic pain to any of the following?

menstruation ☐ pregnancy ☐ delivery ☐ medication ☐ surgery ☐ menopause ☐

eating ☐ urination ☐ bowel movements ☐ intercourse ☐ vaginal infection ☐

SEXUAL FUNCTION

Do you have sexual relations? yes/no

If no:

How long have you abstained from sexual relations?_____months/years

Do you tie your abstinence to any of the following?

spouse ☐ lack of spouse ☐ pregnancy ☐ delivery ☐ medication ☐ surgery ☐ menopause ☐

If yes:

Do you experience painful intercourse?

none ☐ minimally ☐ moderately ☐ severely ☐

How does this effect your frequency of intercourse?

none ☐ minimally ☐ moderately ☐ severely ☐

If you experience painful intercourse:

Is it painful at the time of insertion?

none ☐ minimally ☐ moderately ☐ severely ☐

Is it painful with deep penetration?

none ☐ minimally ☐ moderately ☐ severely ☐

How do the following effect your sexual relations?

	None	Minimally	Moderately	Severely
Spouse limitations				
Urinary incontinence				
Prolapse				
Anal incontinence				
Pelvic pain				
Pain with intercourse				

This form was completed by:

Physician_____ Patient and reviewed with physician_____