Patient Name: _____
DOB: _____/ _____/ _____ Age: _____

PELVIC SYMPTOM QUESTIONNAIRE

Bladder

1. Average fluid intake (one glass in 8 oz., or one cup): ____ glasses per day. Of this total, how many glasses are caffeinated? ____ glasses per day. Type of caffeinated beverage: _____
2. Frequency of urination: Awake hours _____times per day Sleep hours _____times per day
3. How urgent is your need to go to the restroom: ____minimal ____moderate ____excessive
4. 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
5. The usual amount of urine passed is: ____ small ____medium ____large

Y/N Trouble initiating urine stream
Y/N Difficulty stopping urine stream
Y/N Dribbling after urination
Y/N Recurrent bladder infections
Y/N Urinary intermittent/slow stream
Y/N Trouble emptying bladder completely
Y/N Constant urine leakage
Y/N Painful urination/burning
Y/N Strain or push to empty bladder
Y/N Blood in urine
Y/N Trouble feeling bladder urge
Y/N Have "falling out" feeling

Y/N Other, please describe: _____
Describe typical position for emptying: _____

6. Bladder leakage- number of episodes

_____ No leakage
_____ Times per day
_____ Times per week
_____ Times per month
_____ Only with physical exertion/ cough

6b. On average, how much urine do you leak?
_____ No leakage
_____ Just a few drops
_____ Wets underwear
_____ Wets outerwear
_____ Wets the floor

Rate a feeling of an organ "falling out"/ prolapsed or pelvic heaviness or pressure:

____ None present
____ Times per month (specify if related to activity or menstrual period)
____ With standing for ___ minutes or ___ hours
____ With exertion or straining
____ Other: _____

Protection: What form of protection do you wear? (Please select only one)

____ None
____ Minimal protection (tissue paper/panty shield)
____ 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

Bowel

1. Frequency of bowel movements: ____ times per day ____times per week Other: _____
2. The bowel movements are typically: ____watery ____loose ____formed ____pellets Other: _____
3. If constipation is present, describe management techniques: _____
4. When you have an urge to have a bowel movement, how long can you delay before going to the toilet?
   _____ Minutes _____Hours _____Not at all

Y/N Blood in stool/feces	Y/N Painful bowel movements (BM)	Y/N Trouble feeling bowel urge/fulliness
Y/N Seepage/loose 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 touch to complete BM	Y/N Staining on underwear after BM
Y/N Constipation/straining ___% of the time	Y/N Current laxative use	Y/N Other, please describe: _____

Describe typical position for emptying: _____

5. Bowel leakage – number of episodes
   _____No leakage
   _____Times per day
   _____Times per week
   _____Times per month
   _____Only with physical exertion

   5b. How much stool do you lose?

_____No leakage
_____Stool staining
_____Small amount in underwear
_____Complete emptying
_____Other: _____