Cottage Rehabilitation Hospital

Keck Center for Outpatient Services
2415 De La Vina Street
Santa Barbara, CA 93102-3819
805-569-8900 ext. 82400

Cottage Rehabilitation Hospital
Physical Therapy Services

Pelvic Symptoms Questionnaire

1. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than_____ minutes
___ Walking greater than _____minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers i.e. /key in door
___ With nervousness/anxiety
___ No activity affects the problem

2. How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

3. What are your treatment goals?_____

4. Date of Last Physical Exam _____ Tests performed_____

General Health: Excellent Good Average Fair Poor
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____
Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

Osteoporosis	Hypothyroid/ Hyperthyroid	Low back pain
Chronic Fatigue Syndrome	Headaches	Sacroiliac/Tailbone pain Fibromyalgia
Diabetes	Kidney disease	
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Sexually transmitted disease	Smoking history
Physical or Sexual abuse	Sports Injuries	Raynaud's (cold hands and feet)
TMJ/ neck pain	Pelvic pain	

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #__	Y/N	Vaginal dryness
Y/N	Episiotomy #___	Y/N	Painful periods
Y/N	C-Section #____	Y/N	Menopause - when? ___
Y/N	Difficult childbirth #___	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic/genital pain_____
Y/N	Other /describe_____		

Males only

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic/genital pain location _____
Y/N Other /describe _____

Y/N Erectile dysfunction
Y/N Painful ejaculation

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining _____% of time
Y/N	Painful urination	Y/N	Current laxative use -type _____
Y/N	Other/describe _____		

1. Frequency of urination: awake hour's ____ times per day, sleep hours ____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all
3. The usual amount of urine passed is: ___small ___ medium___ large
4. Frequency of bowel movements _____ times per day, _____times per week, or _____.
5. The bowel movements typically are: watery ___ loose ___ formed___ pellets ___ other _____
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____minutes, _____hours, _____not at all.
7. If constipation is present describe management techniques _____
8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
   Of this total how many glasses are caffeinated?_____ glasses per day.
9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:

___None present
___Times per month (specify if related to activity or your menstrual period)
___With standing for _____ minutes or _____hours.
___With exertion or straining
___Other _____

10a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor

11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other _____

12. What form of protection do you wear? (Please complete only one)

___None
___Minimal protection (tissue paper/paper towel/pantishields)
___Moderate protection (absorbent product, maxi pad)
___Maximum protection (specialty product/diaper)
___Other _____

On average, how many pad/protection changes are required in 24 hours? _____# of pads