WOMEN'S HEALTH QUESTIONNAIRE

Name: _____ Birthdate:_____

Describe the current problem: _____

When did the problem begin? _____

Pelvic Pain

Pain wearing tight clothing? Y N

Pain worsens with walking? Y N

Pain with sitting? Y N

Require pain medication? Y N

Pain with bowel movement? Y N

Limited social outings due to pain? Y N

Pain with speculum exams? Y N

Pain inserting tampon? Y N

Pain with sexual intercourse? Y N

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

___Sitting greater than ___ minutes

___ With cough/sneeze/straining

___ Walking greater than _____ minutes

___ With laughing/yelling

___ Standing greater than _____ minutes

___ With lifting/bending

___ Changing positions (i.e. - sit to stand)

___ With cold weather

___Light activity (light housework)

___With triggers -running water/key in door

___ Vigorous activity/exercise (run/weight lift/jump)

___ With nervousness/anxiety

___ Sexual activity

___ No activity affects the problem

What relieves your symptoms?

_____

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 _____

Rate the severity of this problem from 0 -10 (0 being no problem and 10 being the worst) _____

What are your treatment goals/concerns? _____

Surgical /Procedure History

Y N Surgery for your back/spine

Y N Surgery for your bladder

Y N Surgery for your female organs

Y N Surgery for your abdominal organs

Other/describe:_____

Ob/Gyn History

Y/N Childbirth vaginal deliveries #

Y/N Vaginal dryness:

Y/N Episiotomy #

Y/N Painful periods:

Y/N C-Section #

Y/N Menopause

Y/N Difficult childbirth #

Y/N Painful vaginal penetration

Y/N Prolapse or organ falling out

Y/N Pelvic pain

Y/N Other describe:_____

Pelvic Symptom Questionnaire-- Bladder / Bowel Habits / Problems

Y/N Trouble initiating urine stream

Y/N Blood in urine

Y/N Urinary intermittent /slow stream

Y/N Painful urination

Y/N Trouble emptying bladder

Y/N Trouble feeling bladder urge/fullness

Y/N Difficulty stopping the urine stream

Y/N Current laxative use

Y/N Trouble emptying bladder completely

Y/N Trouble feeling bowel/urge/fullness

Y/N Straining or pushing to empty bladder

Y/N Constipation/straining

Y/N Dribbling after urination

Y/N Trouble holding back gas

Y/N Constant urine leakage

Y/N Recurrent bladder infections

Y/N Pain with bowel movement

Y/N Pain with sexual intercourse

Y/N Trouble emptying with bowel movement

Y/N Smearing of feces in underwear

Y/N Leaking of feces

Y/N Feelings of bloating or gassiness

Y/N Abdominal pain

Frequency of urination: awake hour's times per day?

sleep hours times per night?

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

The usual amount of urine passed is: ___small ___ medium___ large.

Frequency of bowel movements: _____ times per day, times per week. Do you have a regular bowel schedule?

When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet?

If constipation is present, please describe management techniques

What is the consistency of bowel movements:

Average fluid intake (one glass is 8 oz. or one cup)

Of this total how many glasses are caffeinated?___ glasses per day.

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

___None present

___Times per month (specify if related to activity or your period)

___With standing for minutes or hours.

___With exertion or straining

___Other

Skip this page if you don't experience leakage/incontinence

Bladder leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with physical exertion/cough

Bowel leakage - number of episodes

___ No leakage

___ Times per day

___ Times per week

___ Times per month

___ Only with exertion/strong urge

On average, how much urine do you leak?

__ No leakage

__ Just a few drops

__ Wets underwear

__ Wets outerwear

__ Wets the floor

How much stool do you lose?

__ No leakage

__ Stool staining

__ Small amount in underwear

__ Complete emptying

__ Is the stool formed or loose?

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

___None

___Minimal protection (Tissue paper/paper towel/pantishields)

___Moderate protection (absorbent product, maxipad)

___Maximum protection (Specialty product/diaper)

___Other

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