Patient History

Name _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin?___months ago or ___ years ago.

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how?_____

5. If pain is present rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____
_____

6. Describe previous treatment/exercises_____
_____

7. 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 -running water/key in door
___ With nervousness/anxiety
___ No activity affects the problem

8. What relieves your symptoms?_____
_____

9. 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 _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst __

11. What are your treatment goals/concerns?_____
_____

Since the onset of your current symptoms have you experienced:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling
Y/N	Other /describe_____		

_____

Pg 2 History Name_____

Health History: Date of Last Physical Exam _____ Tests performed_____

_____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Have you fallen in the last 6 months? Y/N
Do you feel safe at your home? Y/N
Do you feel safe in your relationship? Y/N
Mental Health: Current level of stress High___ Med___ Low___ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

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

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	**Allergies-list below**
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your abdominal organs
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female 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 - when? ___
Y/N	Difficult childbirth #_____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain

Other /describe_____

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking

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 or 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 or fullness
Y/N	Straining or pushing to empty bladder	Y/N	Constipation/straining
Y/N	Dribbling after urination	Y/N	Trouble holding back gas/feces
Y/N	Constant urine leakage	Y/N	Recurrent bladder infections

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. 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.
6. If constipation is present describe management techniques _____
7. 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.
8. 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 questions if no leakage/incontinence

9a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough

9b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge

10a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__ Wets underwear
__ Wets outerwear
__ Wets the floor

10b. How much stool do you lose?
__ No leakage
__ Stool staining
__ Small amount in underwear
__ Complete emptying

11. 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? _____

Please check the appropriate box:

Urge Incontinence Questions

Some people receive very little warning and suddenly find that they are losing, or about to lose, urine beyond their control. How often does this happen to you?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

If you can't find a toilet or find a toilet that is occupied and you have an urge to urinate, how often do you end up losing urine and wetting yourself?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Do you lose urine when you suddenly have the feeling that your bladder is full?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does washing your hands cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does cold weather cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does drinking cold beverages cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

TOTAL URGE SCORE _____
URGE SCORE RATIO _____

Stress Incontinence Questions

Does coughing gently cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does coughing hard cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does sneezing cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does lifting things cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does bending over cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does laughing cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does walking briskly cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does straining, if you are constipated, cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

Does getting up from a sitting to a standing position cause you to lose urine?

_____Often (3) ____Sometimes (2) _____Rarely (1) Never (0)_____

TOTAL URGE SCORE _____
URGE SCORE RATIO _____

QUALITY OF LIFE & SYMPTOMS DISTRESS INVENTORY

NAME _____ **DATE** _____

Please answer each question by checking the best response between 0 (not at all) and 3 (greatly).

Incontinence impact questionnaire

Has urinary leakage and/or prolapse affected your:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Ability to do household chores (cooking, housecleaning, laundry)?					PA
2. Physical recreation, such as walking, swimming, or other exercise?					PA
3. Entertainment activities (movies, concerts, etc.)?					T
4. Ability to travel by car or bus more than 30 minutes from home?					T
5. Participation in social activities outside your home?					SR
6. Emotional health (nervousness, depression, etc.)?					EH
7. Feeling frustrated?					EH

Urogenital distress inventory

Do you experience, and, if so, how much are you bothered by:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Frequent urination?					I
2. Urine leakage related to the feeling of urgency?					I
3. Urine leakage related to physical activity, coughing, or sneezing?					S
4. Small amounts of urine leakage (drops)?					S
5. Difficulty emptying your bladder?					OD
6. Pain or discomfort in the lower abdominal or genital area?					OD
7. A feeling of bulging or protrusion in the vaginal area?					OD
8. Bulging or protrusion you can see in the vaginal area?					OD

PA= physical activity; T= travel; SR= social/relationships; EH= emotional health;
OD= obstructive/discomfort symptoms; I= irritative symptoms; S= stress symptoms

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help us understand what is important to patients about their sex lives. Please circle the answer that best answers the questions for you. While answering the questions, consider your sexuality over the past six months. Thank you for your help.

How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated because of lack of sex, etc.

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Do you climax (have an orgasm) when having sexual intercourse with your partner?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Do you feel sexually excited (turned on) when having sexually activity with your partner?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

How satisfied are you with the variety of sexual activities in your current sex life?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Do you feel pain during sexual intercourse?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Are you incontinent of urine (leak urine) with sexual activity?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Does fear of incontinence (either stool or urine) restrict you sexual activity?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Do you avoid sexual intercourse because of bulging of the vagina (either bladder, rectum, or vagina falling out?)

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame, or guilt?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Does your partner have a problem with erections that affects your sexual activity?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Does your partner have a problem with premature ejaculation that affects your sexual activity?

☐Always (4) ☐Usually (3) ☐Sometimes (2) ☐Seldom (1) ☐Never (0)

Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

☐Much less intense (4) ☐Less intense (3) ☐Same intensity (2) ☐More intense (1)
☐Much more intense (0)

Score/date _____/____

KEEPING A RECORD OF BLADDER FUNCTION

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes. **Please complete a bladder log every day for 2 days and bring it with you to your appointment.**

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

INSTRUCTIONS

Column1 – Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold.
Select the hour block that corresponds with the time of day you are recording information.

Column 2 – Type & Amount of Fluid & Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3 – Amount Voided (Urinated): Three methods

Record the time of day and amount voided. Use the first method, unless directed by your health care provider, to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place an S, M, L in the box at the corresponding time interval each time you urinate.
   S- SMALL= seemed like a small amount, or urinate "just in case".
   M- MEDIUM= seemed like an 8 ounce measuring cup would run over.
   L- LARGE= seemed like the amount you urinate when you first wake up in the morning.
2. If you have difficulty gauging the amount of urine, you may record seconds by counting "one–one thousand" (this equals one second) while emptying your bladder.
3. Measure urine amounts with a collection device. The best method is a collection "hat" that can be placed directly over the toilet. Ask your provider where to get one. Some people use 2-4 cup measuring containers, but is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

Column 4 – Amount of Leakage

Record the amount of urine loss at the time it occurred.

S- SMALL= drop or two of urine
M- MEDIUM= wet underwear
L- LARGE= wet outerwear or floor

Column 5 – Was Urge Present

Describe the urge sensation you had as:

1- **MILD**= first sensation of need to go
2- **MODERATE**= stronger sensation or need
3- **STRONG**= need to get to toilet, move aside!

Column 6 – Activity with Leakage

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

Comments – (at the bottom of the log table) Special problems and new, or changes in, medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.

Daily Voiding Log Sample

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided In Ounces or S / M / L or Seconds	Amount of Leakage S / M / L	Was Urge Present 1 / 2 / 3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	L		3	
7:00 am	Coffee, bagel				
8:00 am			M		Fast walking
9:00 am	Apple	M		2	
10:00 am					
11:00 am					
NOON	Tuna sandwich, milk, pear				
1:00 pm					
2:00 pm		M		2	
3:00 pm	Tea, cookies		S		Running water
4:00 pm					
5:00 pm					
6:00 pm	Chicken, corn pudding, salad, apple juice				
7:00 pm					
8:00 pm			S	3	
9:00 pm					
10:00 pm	To bed at 10:30	M		3	
11:00 pm					

Comments: week before period

Number of pads used today: __3____

Daily Voiding Log

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided In Ounces or S / M / L or Seconds	Amount of Leakage S / M / L	Was Urge Present 1 / 2 / 3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
NOON					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments: _____

_____

Number of pads used today: _____

Daily Voiding Log

Time of Day	Type & Amount of Food & Fluid Intake	Amount Voided In Ounces or S / M / L or Seconds	Amount of Leakage S / M / L	Was Urge Present 1 / 2 / 3	Activity With Leakage
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
NOON					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments: _____

_____

Number of pads used today: _____