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_____		

_____

 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 Urinary intermittent /slow stream
Y/N Trouble emptying bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Straining or pushing to empty bladder
Y/N Dribbling after urination
Y/N Constant urine leakage

Y/N Blood in urine
Y/N Painful urination
Y/N Trouble feeling bladder urge or fullness
Y/N Current laxative use
Y/N Trouble feeling bowel urge or fullness
Y/N Constipation/straining
Y/N Trouble holding back gas/feces
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? _____

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 _____/_____

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

These are statements about how your pelvic pain affects your everyday life.

Please check one box for each item below, choosing the one that best describes your situation.
Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment.
Your responses will be kept completely confidential at all times.

1. Because of my pelvic pain
   - ☐ I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.
   - ☐ I can wear closer-fitting clothing as long as it only puts a little bit of pressure over my painful area.
   - ☐ I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.
   - ☐ I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain
   - ☐ Gets worse when I walk, so I can only walk far enough to move around in my house, no further.
   - ☐ Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
   - ☐ Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
   - ☐ My pain does not get worse with walking; I can walk as far as I want to.
   - ☐ I have a hard time walking because of another medical problem, but my pelvic pain doesn't make it hard to walk.

3. My pelvic pain
   - ☐ Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
   - ☐ Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
   - ☐ Occasionally gets worse when I sit, but most of the time sitting is comfortable.
   - ☐ My pain does not get worse with sitting, I can sit as long as I want to.
   - ☐ I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills I take for my pelvic pain
   - ☐ I am sleepy and I have trouble concentrating at work or while I do housework.
   - ☐ I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
   - ☐ I can do all of my work and go out in the evening if I want, but I feel out of sorts.
   - ☐ I don't have any problems with the pills that I take for pelvic pain.
   - ☐ I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain
   - ☐ I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
   - ☐ It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
   - ☐ Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
   - ☐ It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
   - ☐ I don't get together with my friends or go out to parties or events.
   - ☐ I only get together with my friends or go out to parties or events every now and then.
   - ☐ I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
   - ☐ I get together with friends or go to events whenever I want; pelvic pain does not get in the way.

7. Because of my pelvic pain
   - ☐ I can't stand for the doctor to insert the speculum when I go to the gynecologist.
   - ☐ I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
   - ☐ It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
   - ☐ It never hurts for the doctor to insert the speculum when I go to the gynecologist.

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 they can be difficult to catch the urine with. 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: _____