PATIENT SELF HISTORY

Name:_____ Date:_____ Physician:_____

1. Please describe your main problem

2. When did it begin?

3. Is it getting (circle one) better worse staying the same

4. List the activities or events that cause you to leak urine

5. How has this problem affected your life?

6. What do you hope to gain from this program?

7. How often do you leak urine (circle one)?

never	less than once a month	about once a month
more than once a month	less than once a week	about once a week
more than once a week	almost every day	every day

8. When you leak, approximately how much do you leak (circle one)?

few drops	quarter cup	half a cup
full cup	more than a cup	varies

9. How often do you empty your bladder during the daytime (circle one)?

every 6 to 8 hours	every 3 to 5 hours	every 2 to 3 hours
every hour	every 30 minutes	varies

10. How many times do you get up at night to empty your bladder?

11. How long can you delay the need to urinate (circle one)?

not at all	one to two minutes	less than 10 minutes
15 minutes	30 minutes	1 hour or more

12. Which type of absorbent product do you use (circle one)?

None	panty liner	mini pad
Maxi pad	full sized brief	

13. Do you ever have trouble initiating a urine stream?

14. How many glasses of water and other fluids (milk, soda, coffee, tea, etc.) do you drink each day?

15. How many caffeinated beverages do you drink each day?

16. Do you have problems with constipation? Yes No
    Do you use laxatives or enemas? Yes No

17. How many bowel movements do you have each week?

18. How often do you leak stool by accident (circle one)?

never	less than once a month	about once a month
more than once a month	less than once a week	about once a week
more than once a week	almost every day	every day

19. List all medical conditions and previous surgeries

20. Are you sexually active? Yes No

21. Do you have a history of, or do you currently have a sexually transmitted disease?
    Yes No

22. Women, are you pregnant or attempting pregnancy? Yes No
    Please list number of pregnancies_____number of deliveries_____
    Any Complications?

23. List medications you are currently taking

24. Have you ever been taught to do pelvic floor or Kegel exercise? Yes No

25. If so, by whom? _____ How often do you do them?_____

26. Any other information you feel is important to share?

Pelvic Symptom Questionnaire

Bladder/ Bowel Habits/Symptoms

Y/N Trouble initiating urine stream
Y/N Urinary intermittent/slow stream
Y/N Strain or push to empty bladder
Y/N Difficulty stopping urine stream
Y/N Trouble emptying bladder completely
Y/N Blood in urine
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Trouble feeling bladder urge/fullness
Y/N Recurrent bladder infections
Y/N Painful urination
Y/N Other if yes, describe_____

Y/N Blood in stool/feces
Y/N Painful bowel movements (BM)
Y/N Trouble feeling bowel urge/fullness
Y/N Seepage/loss of BM without awareness
Y/N Trouble controlling bowel urge
Y/N Trouble holding back gas/feces
Y/N Trouble emptying bowel completely
Y/N Need to support/ touch to complete BM
Y/N Straining of underwear after BM
Y/N Constipation/straining_____% of the time
Y/N Current laxative use –type _____

Describe typical position for emptying:_____

1. Frequency of urination: awake hours_ 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 movements, 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 8oz or one cup) ____ 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 menstrual period)
___With standing for _____minutes or_____hours.
___With exertion or straining
___Other_____.

10 a. Bladder leakage- number of episodes
- ___No leakage
- ___Times per day
- ___Times per week
- ___Times per month
- ___Only with physical exertion/cough

b. Bowel leakage- number of episodes
- ___No leakage
- ___Times per day
- ___Times per week
- ___Times per month
- ___Only with physical exertion/strong urge

11 a. On average, how much urine do you leak?
- ___No leakage
- ___Just a few drops
- ___Wets underwear
- ___Wets outerwear
- ___Wets floor

b. How much stool do you lose?
- ___No leakage
- ___Stool straining
- ___Small amount in underwear
- ___Complete emptying
- ___Other_____

12. What for of protection do you wear? (Please mark only one)
- ___None
- ___Minimal protection (tissue paper, paper towel, panty shields)
- ___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.

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 (cook, clean, laundry, etc)					PA
2. Physical recreation such as walking, swimming, or other exercise?					PA
3. Entertainment activities (movies, concets, 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;