Incontinence and Pelvic Floor Questionnaire

Name: ____________________________  Date: ____________________________

The following questions are related to your bladder symptoms or pelvic/vaginal pressure, and its impact upon you.

1: Overall, how frustrated are you with your bladder control:

- [ ] Not at All  - [ ] Slightly  - [ ] Somewhat  - [ ] Moderately  - [ ] Greatly

2: How much has this problem affected your emotional health: (depressed mood, nervousness, unwilling to leave the house etc.)

- [ ] Not at All  - [ ] Slightly  - [ ] Somewhat  - [ ] Moderately  - [ ] Greatly

3: How has your bladder problem affected your ability to exercise or work?

- [ ] Not at All  - [ ] Slightly  - [ ] Somewhat  - [ ] Moderately  - [ ] Greatly

4: Do you feel that you empty your bladder completely after voiding? If not, how much does it bother you?

- [ ] Not at All  - [ ] Slightly  - [ ] Somewhat  - [ ] Moderately  - [ ] Greatly

5: How frequently do you usually need to go to the bathroom to urinate during the day?

- [ ] Every Hour  - [ ] Two Hours  - [ ] Three Hours  - [ ] Four Hours  - [ ] More than Four

6. If you do go to the restroom frequently, how much does it bother you?

- [ ] Not at All  - [ ] Slightly  - [ ] Somewhat  - [ ] Moderately  - [ ] Greatly
7. When you need to use the restroom, do you often need to hurry or can you take your time and go when you want to?

☐ Hurry  ☐ Take Time

8. If you have a strong urge to urinate, could you possibly leak prior to reaching the restroom?

☐ Yes  ☐ No

How much does this bother you?

☐ Not at All  ☐ Slightly  ☐ Somewhat  ☐ Moderately  ☐ Greatly

9. How many times do you need to get up during the night to go to the bathroom?

[ ]

10. How bothered are you by urine leakage related to physical activity?

☐ Not at All  ☐ Slightly  ☐ Somewhat  ☐ Moderately  ☐ Greatly

Check all activities which result in accidental leakage:

☐ Coughing  ☐ Sneezing  ☐ Jumping
☐ Laughing  ☐ Exercising  ☐ Bending

11. Do you have more bladder infections than you believe you should?

☐ Yes  ☐ No
Pelvic Floor Questions:

12: Do you have any pain or pressure in the lower abdomen or genital area, and if so, how much does it bother you?

☐ Not at All  ☐ Slightly  ☐ Somewhat  ☐ Moderately  ☐ Greatly

13: How much does your uncontrolled leakage of urine or vaginal pro-lapse affect your sex life?

☐ Not at All  ☐ Slightly  ☐ Somewhat  ☐ Moderately  ☐ Greatly

14: Do you or your partner feel that your vagina is “too loose” for enjoyable intercourse?

☐ Yes  ☐ No

Bowel Symptoms:

15: Do you have any uncontrollable escape of gas?

☐ Yes  ☐ No

16: Do you have any uncontrollable escape of stool? (beyond your control)

☐ Yes  ☐ No

17: Do you feel that you need to strain excessively to have a bowel movement?

☐ Yes  ☐ No

18: Do you feel that you are not able to completely empty your bowels at the end of a BM?

☐ Yes  ☐ No

19: Do you have pain in your bladder?

☐ Yes  ☐ No