Newport Urogynecology
restoring total health for women

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

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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 in 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