Name: _____ Date: _____ Referring Provider: _____

Age: _____ D.O.B. _____ Race/ ethnicity: _____

What is the nature of your current gynecologic or urologic medical problem (use the other side if necessary).

_____

_____

_____

_____

**We are interested in learning more about how your bowels and bladder work in your typical or usual week while you are doing regular activities - Please place an "X" under the appropriate answer.**

| | | No | Yes | |
|---|---|---|---|---|
| 1. | In a typical week, do you have frequent, strong urges to urinate? | ☐ | ☐ | |
| | | No | Yes | |
| 2. | In a typical week, do you leak urine when you do not want to? | ☐ | ☐ | |
| | | No | Yes | |
| 3. | In a typical week, do you have difficulty emptying your bladder? | ☐ | ☐ | |
| 4. | In a typical week without the use of laxatives (enema, suppository, oral laxative), how many bowel movements do you have? | # _____ | | |
| 5. | In a typical week, how many laxatives do you use? | # _____ | | |
| | | No | Yes | |
| 6. | In a typical week, do you have difficulty having bowel movements? (pain, hard bowel movements, strain or use your hand to get the stool out) | ☐ | ☐ | |
| | | No | Yes | |
| 7. | In a typical week, do you lose stool or bowel movement when you do not want to? | ☐ | ☐ | |
| | | No | Yes | |
| 8. | Do you feel like your rectum, bladder, uterus, or vagina is falling out? | ☐ | ☐ | |
| | | No | Yes | Does not apply |
| 9. | Do you have any physical problems with sexual relations? | ☐ | ☐ | ☐ |

10. During the night, how many times did you have to get up to urinate on average?

None ☐ One ☐ Two ☐ Three ☐ Four or more ☐

**Past Medical History**: Check (√) if your answer is yes.

As an adult, have you had:

| | | |
|---|---|---|
| ____ Heart disease | ____ Liver disease | ____ Asthma |
| ____ Heart murmur | ____ Tuberculosis | ____ Jaundice |
| ____ Kidney disease | ____ Thyroid disease | ____ Diabetes |
| ____ Kidney infection | ____ Pneumonia | ____ Cancer |
| ____ Bladder infection | ____ Bowel disease | ____ High blood pressure |
| ____ Parkinsonism | ____ Stroke | ____ Nerve disorder |
| ____ Serious injuries | ____ Arthritis/Other joint problems | |

**Obstetrical History:**

| | No | Yes | |
|---|---|---|---|
| _____ Number of pregnancies | | | |
| _____ Number of children born | | | During delivery, did you ever have a tear in the rectum? |
| _____ Total number of cesarean sections | | | During delivery, were forceps used? |
| _____ Weight of largest infant born | | | Did you ever have a vacuum assisted delivery? |

**Gynecological History:**

| | No | Yes | |
|---|---|---|---|
| _____ Date of last menstrual period | | | Are you sexually active at this time? |
| _____ Method of birth control | | | _____ If yes, how long have you been with your current partner? |
| | | | Is your sex life satisfactory for you? |

**Surgical History:**

If you have had any operations, please list them here:

| Surgery | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |

**Cancer Screening History:**

Date of last pap smear: _____ Was it normal? _____

Date of last mammogram: _____ Was it normal? _____

Date of last screen for colorectal cancer: _____

____ Colonoscopy ___ Sigmoidoscopy ___ Stool test for blood

**Family History:**

Has anyone in your family had any of these diseases? If so, please give relationship to you.

Breast Cancer _____ Heart Disease _____

Ovarian Cancer _____

Other Cancer(s), please list: _____

Other Disease(s), please list: _____

**Social/Family Supports:**

Who is your main support person (partner/spouse/friend)? _____

**Health Habits:**

| | No | Yes | |
|---|---|---|---|
| Do you smoke? | | | Quit - when? _____ |
| Do you drink alcohol? | | | |
| Do you exercise regularly? | | | How often do you exercise? _____ |

What type of exercise do you do? _____

**Medicines/Physicians:**

List any drug allergies: _____

Please list your doctors, all medications they prescribe for you and the dosage (if possible).

Doctor: _____ Medications: _____

Doctor: _____ Medications: _____

Doctor _____ Medications _____

Please list any other herbs/supplements you take: _____

**General Symptoms: Please check (□) if you recently had:**

**Constitutional:**

- □ Fever, chills
- □ Sweating at night
- □ Recent weight loss
- □ Recent weight gain
- □ Change in appetite
- □ Loss of hair
- □ Intolerance to heat
- □ Intolerance to cold
- □ Excessive water drinking
- □ Weakness
- □ Fatigue

**Ears, Nose, Mouth and Throat**

- □ Ear pain of ear infections
- □ Ringing in ears
- □ Decreased hearing
- □ Sores in mouth/bleeding gums
- □ Hoarseness
- □ Sinus infections
- □ Throat infections

**Eyes:**

- □ Blurry vision
- □ Glaucoma

**Respiratory**

- □ Cough
- □ Coughing with blood
- □ Chest x-ray, if so, Date:
- □ Difficulty breathing
  - □ With laying down
  - □ With exercise
  - □ During sleep

**Cardiovascular:**

- □ Swelling of legs
- □ Varicose veins
- □ Heart murmur

**Gastrointestinal:**

- □ Bad food digestion
- □ Hemorrhoids
- □ Change in bowel habits
- □ Nausea
- □ Vomiting
- □ Difficulty swallowing
- □ Vomiting blood
- □ Diarrhea
- □ Black stool

**Musculoskeletal:**

- □ Pain in legs with exercise

**Neurological:**

- □ Fainting
- □ Tremors
- □ Stroke
- □ Convulsions
- □ Severe headaches
- □ Dizziness

**Skin:**

- □ Itching
- □ Skin rashes
- □ Skin infections
- □ Change in any mole

**Psychiatric:**

- □ Psychiatric treatment
- □ Depression
- □ Thoughts of suicide
- □ Nervousness

**Endocrine:**

- □ Breast lump
- □ Breast size change
- □ Nipple discharge
- □ Breast pain
- □ Enlarged thyroid
- □ Gland enlargement in

**Hematologic/Lymphatic:**

- □ Blood clots
- □ Prolonged bleeding
- □ Easy bruising
- □ Low blood count (anemia)
- □ Frequent bloody nose

**Allergic/Immunologic:**

- □ Hayfever
- □ Asthma

Other: _____

# Pelvic Floor Questionnaire (PFDI)

*Instructions:*

**Please answer the following questions by placing an "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the last three months. Thank you for your help.**

Date: ____/____/____

| | | No | Yes | If yes, how much does this bother you? | Not at all | Somewhat | Moderately | Quite a bit |
|---|---|---|---|---|---|---|---|---|
| 1. | Do you usually experience *pressure* in the lower abdomen? | | | | 1 | 2 | 3 | 4 |
| 2. | Do you usually experience *heaviness or dullness* in the pelvic area? | | | | 1 | 2 | 3 | 4 |
| 3. | Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? | | | | 1 | 2 | 3 | 4 |
| 4. | Do you usually have to push on the vagina or around the rectum to have or complete bowel movement? | | | | 1 | 2 | 3 | 4 |
| 5. | Do you usually experience a feeling or incomplete bladder emptying? | | | | 1 | 2 | 3 | 4 |
| 6. | Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? | | | | 1 | 2 | 3 | 4 |
| 7. | Do you feel you need to strain too hard to have a bowel movement? | | | If other than never, how much does this bother you? | 1 | 2 | 3 | 4 |
| 8. | Do you feel you have not completely emptied your bowels at the end of a bowel movement? | | | If other than never, how much does this bother you? | 1 | 2 | 3 | 4 |
| 9. | Do you usually lose stool beyond your control if your stool is well formed? | | | | 1 | 2 | 3 | 4 |
| 10. | Do you usually lose stool beyond your control if your stool is loose or liquid? | | | | 1 | 2 | 3 | 4 |

| | No | Yes | | Not at all | Somewhat | Moderately | Quite a bit |
|---|---|---|---|---|---|---|---|
| 11. Do you usually lose gas from the rectum beyond your control? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 12. Do you usually have pain when you pass your stool? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? | | | If other than never, how much does this bother you? | 1 | 2 | 3 | 4 |
| 14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 15. Do you usually experience frequent urination? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 16. Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 18. Do you usually experience small amounts of urine leakage (that is, drops)? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 19. Do you usually experience difficulty emptying your bladder? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |
| 20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region? | | | If yes, how much does this bother you? | 1 | 2 | 3 | 4 |