MARATHON

PHYSICAL THERAPY AND SPORTS MEDICINE www.MarathonPhysicalTherapy.com

425 CENTRE STREET, NEWTON, MA 02458 ● 617-244-1990 ● FAX 617-244-1811

PELVIC FLOOR PHYSICAL THERAPY QUESTIONNAIRE

NAME:____________________________________ **DATE:_____________**

Answering the following questions will help us to manage your care better.
Do you now have or have you had a history of the following?

Y/N Yeast/ Bladder infections
Y/N Painful intercourse
Y/N Constipation
Y/N Diabetes
Y/N Neurological Muscle Disorders
Y/N Asthma
Y/N Allergies
Y/N Smoking habit
Y/N Sexually transmitted disease or other communicable disease
Y/N Depression
Y/N Thyroid dysfunction
Y/N Pelvic Pain
Y/N Low back pain
Y/N Arthritis/ Rheumatoid arthritis
Y/N Abdominal pain
Y/N Stroke
Y/N Heart disease/ Pacemaker
Y/N Emphysema/ Bronchitis/ Lung disease
Y/N Circulatory problems
Y/N Cancer, please specify _____________
Y/N Gastrointestinal or irritable bowel disease
Y/N Trauma to the pelvis (i.e. fall)
Y/N Other______________________

<u>For female patients</u>:

Y/N Menopause
Y/N Are you currently pregnant?
Y/N Actively trying to conceive?
Y/N Have you ever been pregnant? Please list number, date(s) and delivery method below:

____
____
____

Did you have an episiotomy? Tearing and stitching? ______________________________________
____

During a gynecological exam, do you experience pain with the speculum? Yes No

<u>For male patients</u>:

Y/N Testicular pain?
Y/N Erectile dynfunction?
Y/N Prostate disease? Please specify disease and treatment below:

____
____
____

For all patients:

Please explain and provide dates for any additional "yes" answers:

____

____

____

____

Please list any past surgical procedures: ______________________________

____

____

____

Please list any current medications you are taking (prescription and over the counter) and for what reason:

____

____

____

What is your work status? Is physical activity required in this position? ____________

____

Do you exercise? Please give description: ______________________________

____

	Always	Sometimes	Never
Do you have trouble making it to the toilet in time?	_____	________	_____
Do you lose urine when you have a strong urge to urinate?	_____	________	_____
Do you lose urine with any of the following:			
Coughing or sneezing	_____	________	_____
Laughing	_____	________	_____
Lifting	_____	________	_____
Active exercise (running, etc)	_____	________	_____
Minimal exercise (walking, light housework)	_____	________	_____
Sleeping	_____	________	_____
Nervousness/increased anxiety	_____	________	_____
Leakage unrelated to any specific cause	_____	________	_____
Other:	_____	________	_____
	_____	________	_____

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1. Do you experience leakage: never___ 1/week ___ 2-3/week ___ 1/month ___ >1/day ___
2. Amount of Leakage: ___ None ___ small amount ___ moderate amount ___ large amount
3. Do you use sanitary pads?___ tissue paper?___ diapers?___
4. How many pads per day?___
5. How often do you urinate during the day?____
6. How often do you urinate at night?____
7. Is the volume of urine you usually pass: large?___ average?___ small?___ very small?___
8. Do you experience any of the following Voiding Symptoms: incomplete emptying? ____ hesitancy? ____ slow stream? ____ intermittent stream? ____
9. Do you urinate frequently, before you experience the urge, just so you can stay dry? Yes____ No____
10. How many glasses of fluid do you drink per day?_________
11. How many beverages are caffeinated?________
12. Any bowel or gas control problems? Please explain: _________________________________
____
____
13. Are you currently sexually active? Yes No
    13a. If “no”, have you been sexually active in the past? Yes No
    13b. If “yes” to 16a, are you currently refraining from sexual activity because of the problem(s) that bring you to physical therapy?
14. Does your sexual practice (past or present) include any anal entry activities? Yes No
15. Do you experience/Have you experienced painful intercourse (Dyspareunia)? Yes No
16. Have you ever experienced physical, sexual, verbal or emotional abuse or trauma? Yes No
    16a. If “yes”, is the abuse occurring currently? Yes No
    16b. If “yes” to 16, is this still a factor in your life physically, emotionally and/or psychologically? Yes No