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FEMALE PELVIC SYMPTOM QUESTIONNAIRE

This question sheet has been provided to give you some idea of the symptoms that we are interested in, so please use it to help you as an aid for when you come to the clinic, but it will also help us with the management of your problem. If you do not understand any of the questions, do not be concerned as we will go through your history in detail and explain the questions at the time of your consultation.

Can you please list your three main problems in order of importance?

1. ……
2. ……
3. ……..

NAME:

DOB:

When you answer the questions below, please consider how troublesome these symptoms are to you.

BLADDER SYMPTOMS – Please select the best answer

Do you leak when you cough, run, jump or sneeze? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Do you have to rush to the toilet to pass urine? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

If so, do you ever leak urine before getting there: Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

If you leak urine, do you have to wear pads? Yes / No
If yes – it is just for protection daily but are wet daily soaked

How many pads do you use per day? _____

Do you go to the toilet more than every hour during the day? Yes / No

How many times do you go to the toilet at night? _____

Do you leak urine lying down at night? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Do you leak urine when you stand up, especially at night? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Did you wet the bed after the age of 8 years old? Yes / No

Have you ever not been able to pass urine & need a catheter? Yes / No

How many cups of tea & coffee do you drink a day? _____

How many glasses of fizzy drinks and cordial do you drink a day? _____

PASSING URINE – Please select the best answer

Do you feel the flow of urine to be less than you expect? Yes / No

Do you have to strain to pass urine? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Do you feel you don't empty your bladder properly? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Do you hesitate to start: Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Do you have dribbling at the end? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Do you have to go back to the toilet a second time, soon after passing urine? Yes / No

Does your flow stop / start when passing urine? Yes / No

Do you have pain when you empty your bladder or when it fills? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Have you had blood in your urine? Yes / No

Have you had more than two urinary tract infections in the last year? Yes / No

BOWEL SYMPTOMS – Please select the best answer

Do you suffer constipation? Yes / No

If so, how often do you go to the toilet to open your bowels? _____

Do you need to strain to pass motions? Yes / No
If yes – is this rarely (monthly) occasionally (weekly) frequently (every day)

Are they normal consistency & colour? Yes / No

Do you have blood in your motions? Yes / No

Do you need to use pressure near your vagina to help you pass motions? Yes / No

Is it painful to pass motions? Yes / No

Do you suffer with incontinence of faeces? Yes / No
If yes – is this mild moderate severe

PROLAPSE

Do you feel a lump coming down? Yes / No

Do you have a dragging discomfort in the pelvis when moving around? Yes / No

Do you feel an aching in the top of your thighs? Yes / No

CHILDBIRTH

Do you have children? Yes / No

If so, did you have vaginal childbirth? Yes / No

Did you have any problems, particularly tears, forceps or difficult births? Yes / No

How many children do you have? _____

SEXUAL INTERCOURSE (Optional to answer)

Although you may feel embarrassed about these questions, it is important to think about them as they may affect your treatment.

Do you still have intercourse? Yes / No

If yes, how often per month? _____

If so, is it painful? Yes / No

Is the pain a deep ache? Yes / No

And / or more superficial soreness at the opening of the vagina? Yes / No

Do you feel the vagina may be too tight? Yes / No

Do you feel the vagina muscles are too loose? Yes / No

Do you have a feeling of passing wind out of the vagina ever? Yes / No

LIFESTYLE QUESTIONS

Does your work or home duties involve a lot of heavy lifting or straining? Yes / No

Do you have a chronic cough or asthma? Yes / No

FINAL QUESTIONS

Have you had any previous treatment such as the following?

Medication to stop you from passing urine too often? Yes / No

If so what medication? _____

Hormone cream in the vagina? Yes / No

Physiotherapy Yes / No

Have you had any tests done for this problem recently? Yes / No

If so, what tests have you had performed and when? _____

Thank you for spending the time to complete this questionnaire, as it will assist us to come to the correct diagnosis and plan the correct management for your problem.