

PELVIC FLOOR INFORMATION FORM - WOMEN

Name _____ Date _____

What is the approximate date this problem began? _____

Did this condition begin suddenly or gradually (circle one)

My problem is getting better getting worse about the same (circle one)

Please describe your symptoms: _____

Please rate your pain or symptoms on a scale of 0 to 10:

today _____

1 - mild and doesn't interfere with activities

5 - moderate with noticeable discomfort

at best _____

7 - moderate to severe - interferes with

activities, but not disabling

at worst _____

10 - severely disabling, unable to function

Are your symptoms (circle one) constant intermittent?

Do your symptoms change during the day? Yes / No How? _____

Do your symptoms interfere with sleep? Yes / No

What makes the symptoms worse? _____

What makes the symptoms better? _____

Is your condition aggravated by (circle any) sitting standing walking lying down?

Please list **ANY** other medical conditions you have (e.g. high blood pressure,

fibromyalgia, diabetes) _____

Do you have headaches? Yes / No Jaw pain? Yes / No Back pain? Yes / No

Are your stools normal? Yes / No

Do you have (circle one) constipation loose stools both?

Do you have the feeling you have to urinate frequently? Yes / No

How many times per night do you get up to urinate? _____

(please see other side)

Please list **any past** medical conditions (e.g. past surgeries, past illness, past trauma)

Please list **ALL** current medications including over-the-counter and herbals:

Have you ever been pregnant? Yes / No How many times? _____

Do you have any children? Yes / No How many? _____ Ages: _____

Do you have any children living at home? Yes / No How many? _____

Do your symptoms interfere with sexual function? Yes / No

Are you now sexually active? Yes / No

Have you had any sexually transmitted diseases? Yes / No

Have you experienced sexual activity against your will? Yes / No

Are you involved in a routine exercise program? Yes / No If so, what is it? _____

Have you changed your exercise program because of this problem? Yes / No

Are you presently working? Yes / No Occupation _____ hours/week _____

How much do you feel your problem interferes with your everyday activities?

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
Not at all Significantly

How would you rate your stress level?

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Do you smoke? Yes / No Packs/day _____

Are you allergic to any of the following: Latex bananas papayas
(circle any) chestnuts avocados