

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PELVIC FUNCTION QUESTIONNAIRE

1. Approximately how long have you had your bladder or urinary problem(s)?

_____ days	_____ weeks	_____ months	_____ years
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### Urinary Frequency

2. On an average day, how often do you urinate \_\_\_\_\_ hours  
during the daytime? (Every ½ hour, every 2 hours, etc)

3. On a scale of 0-10 (0 is no bother at all, 10 is intolerable),  
how badly does the frequency of urination bother you? \_\_\_\_\_  
Circle one

0	1	2	3	4	5	6	7	8	9	10
none										severe

4. On an average day, why do you urinate as often as you do?

_____ Normal urge	_____ Out of convenience so that you don't have to stop at a bathroom
_____ Pain	_____ Because you're afraid you might lose control

### Nocturia

5. How many times do you wake up at night to urinate?

_____ none	_____ one time	_____ two times	_____ three times	_____ four times	_____ five or more times
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6. Why do you get up to urinate at night?

_____ Awakened by urge to urinate	_____ Urinate because you're already up
_____ Afraid you might wet the bed	_____ Habit _____ N/A

7. On a scale of 0-10 (0 is no bother at all, 10 is intolerable),  
how badly does the urinating at night bother you? \_\_\_\_\_  
Circle one

0	1	2	3	4	5	6	7	8	9	10
none										severe

Urgency

8. When you feel the need to urinate, how often is there a sense of urgency, a feeling that you must rush to the bathroom, a feeling that if you don't get to the bathroom, you will wet your pants?

<input type="checkbox"/> Never	<input type="checkbox"/> Few times/year	<input type="checkbox"/> Few times/month
<input type="checkbox"/> Few times/week	<input type="checkbox"/> Daily	

9. On a scale of 0-10 (0 is no bother at all, 10 is intolerable), how badly does the urgency of urination bother you?

Circle one

0	1	2	3	4	5	6	7	8	9	10
none										severe

Incontinence

10) Do you ever leak or lose control of urination?  Yes  No

11) If you lose control do you know when it happens or do you just find yourself wet?

know when it happens  find myself wet

12) How often do you lose control of urination and wet yourself or your pads because you feel a strong urge and can't stop it?

<input type="checkbox"/> Never	<input type="checkbox"/> Few times/year	<input type="checkbox"/> Few times/month
<input type="checkbox"/> Few times/week	<input type="checkbox"/> Daily	

13) How often do you lose control and wet yourself or your pads when you cough or sneeze?

<input type="checkbox"/> Never	<input type="checkbox"/> Few times/year	<input type="checkbox"/> Few times/month
<input type="checkbox"/> Few times/week	<input type="checkbox"/> Daily	

14) How often do you lose control and wet yourself or your pads when you engage in physical activity? (Running, jumping, lifting, sports, etc.)

<input type="checkbox"/> Never	<input type="checkbox"/> Few times/year	<input type="checkbox"/> Few times/month
<input type="checkbox"/> Few times/week	<input type="checkbox"/> Daily	

15) How often do you lose control and wet yourself or your pads when you raise yourself from a sitting to a standing position?

<input type="checkbox"/> Never	<input type="checkbox"/> Few times/year	<input type="checkbox"/> Few times/month
<input type="checkbox"/> Few times/week	<input type="checkbox"/> Daily	

16) How often do you wear pads or other forms of protection because of the wetting?

_____ Never	_____ Few times/year	_____ Few times/month
_____ Few times/week	_____ Daily	

17) On average, how many pads do you use a day? \_\_\_\_\_

What type of pads are they? (liners, maxi pads, incontinence pads, diapers, etc) \_\_\_\_\_

\_\_\_\_\_

18) On average, how wet are they when you change them?

\_\_\_\_\_ dry \_\_\_\_\_ moist \_\_\_\_\_ damp \_\_\_\_\_ wet \_\_\_\_\_ soaked

19) On a scale of 1-10, how badly does loss of urinary control bother you?

0	1	2	3	4	5	6	7	8	9	10
none										severe

#### Difficulty Urinating

20) How often must you push or strain to start urination?

_____ Never	_____ Few times/year	_____ Few times/month
_____ Few times/week	_____ Daily	

21) How would you describe the usual force of the stream?

_____ Strong	_____ Not as strong as it used to be	_____ Weak
_____ Interrupted (stop and start)	_____ Dribbling	

22) How often do you feel that your bladder is not empty after urinating?

_____ Never	_____ Few times/year	_____ Few times/month
_____ Few times/week	_____ Daily	

23) Have you ever had pain with urination? \_\_\_\_\_ Yes \_\_\_\_\_ No

24) Have you ever had blood in your urine? \_\_\_\_\_ Yes \_\_\_\_\_ No

25) Do you think that you have a dropped bladder or a bulge in the vagina?

\_\_\_\_\_ Yes \_\_\_\_\_ No

26) Have you taken any medications for your bladder condition in the past? If so, please list below:

Medication name:	Dosage:	Response:

27) Do you have urinary leakage and/or pain during sexual intercourse?

_____Leakage	_____Pain	_____Both
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Sexual Function

28) Do you currently have a sexual partner?      \_\_\_\_\_Yes      \_\_\_\_\_No

29) In the last month, how many times have you had sexual relations (including masturbation)?

_____None	_____Once	_____More than once
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30) How frequently have you experienced pain during sexual relations?

\_\_\_\_\_All of the time      \_\_\_\_\_most of the time      \_\_\_\_\_a good bit of the time  
 \_\_\_\_\_some of the time      \_\_\_\_\_little of the time      \_\_\_\_\_none of the time

31) How frequently have you experienced orgasm during sexual relations?

\_\_\_\_\_All of the time      \_\_\_\_\_most of the time      \_\_\_\_\_a good bit of the time  
 \_\_\_\_\_some of the time      \_\_\_\_\_little of the time      \_\_\_\_\_none of the time

32) How frequently have you experienced vaginal dryness during sexual relations?

\_\_\_\_\_All of the time      \_\_\_\_\_most of the time      \_\_\_\_\_a good bit of the time  
 \_\_\_\_\_some of the time      \_\_\_\_\_little of the time      \_\_\_\_\_none of the time

33) How frequently have you desired sex?

\_\_\_\_\_Every day      \_\_\_\_\_ 5-6 days per week      \_\_\_\_\_ 3-4 days per week  
 \_\_\_\_\_ 1-2 days per wk      \_\_\_\_\_ 2-3 days per month      \_\_\_\_\_<1 day per month  
 \_\_\_\_\_ not at all

34) In the last month, how strong has orgasm been for you?

_____Very strong	_____strong	_____mild	_____very mild
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