Gainesville Physical Therapy & Wellness

"Where People Matter and Results Count"

Women's Health Questionnaire

Patient's Name: _____ Date:_____

Describe the reason for your appointment:_____

_____

When did this problem begin?_____ The problem is: ○getting better ○ worse ○ same

1. Bladder leakage frequency:

○Never ○ Only with strong cough or sneeze○ Only premenstrual

Number of Episodes: per month: _____ per week: _____ per day: _____

2. Severity of leakage:

○No leakage ○Few Drops ○Wets Underwear ○ Wets outerwear

3. Protection worn:

○ None ○Tissue paper or paper towel ○Panti shields ○ Mini pads ○Maxi pad ○Diaper

Average # per day: _____

4. Leakage caused by or increased by: (select all that apply)

○ Vigorous activity or exercise (Running, weight lifting, cough/sneeze/laugh)	○Intercourse or sexual activity
○Light activity (Walking, light house work)	○ No activity changes leakage (constant leakage)
○Changing positions (sitting to standing)	○ After emptying bladder
○Walking to the toilet	○ Washing hands
○Strong urge to go	○ Putting key in lock
Other, please list:	

5. Position or activity with leakage?

○ Lying down ○ Sitting ○ Standing ○ Squatting

6. Do you feel a "falling out" or pelvic heaviness/pressure?

○ None	○ Only with menstruation
○ With standing	○ With exertion or straining
○ At the end of each day	○ Present all day

How often do you feel these symptoms? _____

7. Fluid intake (one glass is 8oz or one cup)

# of glasses per day: _____

# of caffeinated glasses per day: _____

# of alcoholic beverages per day: _____

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8. Rate your feeling as to the severity of this problem from 0-10.

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

not a problem major problem

9. Rate the following statement as it applies to you today: "My bladder is controlling my life"

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

not true at all completely true

BLADDER HABITS:

1. How often do you urinate during the day? _____# of times/day
2. How often do you urinate after going to bed? _____# of times at night
3. Do you take your time to go to the toilet and empty your bladder? ○ Yes ○ No
4. Number of bladder infections in the last year? _____
5. Can you stop the flow of urine when on the toilet? ○ Yes ○ No
6. Is the volume of urine passed usually? ○ Large ○ Average ○ Small ○ Very Small
7. Do you have the sensation that you need to go to the toilet? ○ Yes ○ No
8. Do you strain to pass urine? ○ Yes ○ No
9. Do you empty your bladder frequently, before you experience the urge to pass urine? ○ Yes ○ No
10. Do you have the feeling your bladder is still full after urinating? ○ Yes ○ No
11. Do you have a slow hesitant urinary stream? ○ Yes ○ No
12. Do you have difficulty initiating the urine stream? ○ Yes ○ No
13. Do you have "trigger" that make you feel like you can't wait to go to the toilet? (running water, etc) ○ Yes ○ No Please list: _____
14. How long can you delay the need to urinate?

○ Not at all ○ 1-2 Min ○ 3-10 min ○ 11-30 min ○ 31-60 min ○ ___ Hours

BOWEL HABITS:

15. Frequency of bowel movements: ____ per day _____ per week
16. Consistency of stool: ○ Loose ○ Normal ○ Hard
17. History of constipation? ○ Yes ○ No
18. Do you currently strain to go? ○ Yes ○ No
19. Do you ignore the urge to defecate? ○ Yes ○ No
20. Do you have trouble making it to the toilet on time when you have the urge to go? ○ Yes ○ No

Past level of function: BEFORE this problem began your activities were:

○ Normal and unrestricted
○ Minimally restricted
○ Moderately restricted
○ Severely restricted
○ Only heavy activities are restricted

Present level of function: AFTER this problem began your activities were:

○ Normal and unrestricted
○ Minimally restricted
○ Moderately restricted
○ Severely restricted
○ Only heavy activities are restricted

Specifically, what are you not able to do because of your current problem? _____

_____

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Incontinence Impact Section

Patient's Name: _____ Date:_____

Has urine leakage affected your:	Not at all (0)	Slightly (1)	Moderately (2)	Greatly (3)
Ability to do household chores (cooking, housecleaning, laundry)?	○	○	○	○
Physical recreation such as walking, swimming, or other exercise?	○	○	○	○
Entertainment activities (movies, concerts, etc.)	○	○	○	○
Ability to travel by car or bus more than 30 minutes from home?	○	○	○	○
Participation in social activities outside your home?	○	○	○	○
Emotional health (nervousness, depression etc.)	○	○	○	○
Feeling frustrated?	○	○	○	○

Do you experience any urinary incontinence? ○ Yes ○ No

If so, how much are you bothered by:	Not at all (0)	Slightly (1)	Moderately (2)	Greatly (3)
Frequent urination	○	○	○	○
Urine leakage related to feeling of urgency	○	○	○	○
Urine leakage related to physical activity, coughing or sneezing?	○	○	○	○
Small amounts of urine leakage?	○	○	○	○
Difficulty emptying your bladder?	○	○	○	○
Pain or discomfort in the lower abdomen or genital area?	○	○	○	○

Do you have any uncontrolled leakage of ○ gas ○ liquid ○ solid stool ○ none?

On a scale of 0 to 100, where zero represents death and 100 represents perfect health, please indicate how you would rate your current state of health: ___ ___ ___ (1-100)

For Therapist Use:_____

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