PTFW
Business Office
Phone: 817-247-1130
Fax: 817-292-7930

Treatment Locations:
Fort Worth
Dallas
Colleyville

MALE PELVIC FLOOR QUESTIONNAIRE

Name _____ Date_____ Date of Birth _____

Please describe your main problem: _____
_____
When did it begin? _____; is the onset associated with one particular event? If so, what was the event _____; is it getting:
❑ better ❑ worse or ❑ staying the same

Please describe activities or things that you cannot do because of your problem _____
_____

SOCIAL HISTORY:
Marital Status _____ Ages of children living at home _____
Education level _____

Please briefly describe any difficulty moving around (limitations in walking, balance, getting out of a chair, etc.)
_____
_____
_____

What are your hobbies? _____

PLEASE COMPLETE THE FOLLOWING AS COMPLETELY AS POSSIBLY. YOUR THERAPIST WILL DISCUSS THIS INFORMATION WITH YOU.

PELVIC PAIN:
Location of pain _____
What makes your pain better? _____
What makes your pain worse? _____

UROLOGICAL HISTORY:
Date of last urinalysis _____
Special Tests Performed? _____ Type _____ Date _____
Do you have a history or urinary tract infections? ❑ Yes ❑ No If yes, when was your last infection? ____
Do you have a history of urine loss as a child? ❑ Yes ❑ No
as an adolescent? ❑ Yes ❑ No

Have you had:	urethral dilations?	❑ Yes	❑ No	If yes, specify reason:_____
	urodynamic tests?	❑ Yes	❑ No	If yes, specify reason:_____
	recent catheter use?	❑ Yes	❑ No	If yes, specify reason:_____
	cystoscopes?	❑ Yes	❑ No	If yes, specify reason:_____
	prostate enlargement	❑ Yes	❑ No	If yes, specify reason:_____
	prostate surgery	❑ Yes	❑ No	If yes, specify reason:_____

Date of last pelvic examination _____
Previous treatment for incontinence? ❑ Yes ❑ No ___exercises ___medication ___surgery

Have you ever been taught how to do pelvic floor or Kegel exercises? ❑ Yes ❑ No
When? _____ By whom? _____
How often do you do pelvic floor exercises? _____

DO YOU EXPERIENCE A LOSS OF URINE: (*check yes or no*)

With cough, laugh, sneeze?	❑ Yes ❑ No
When lifting objects?	❑ Yes ❑ No
With exercise?	❑ Yes ❑ No
When you have a strong urge to urinate?	❑ Yes ❑ No
On your way to the bathroom?	❑ Yes ❑ No
Just as you get to the toilet/remove clothing?	❑ Yes ❑ No
Other episodes of incontinence?	❑ Yes ❑ No

DO YOU: (*check yes or no*)

Experience an urge to urinate when you hear running water?	❑ Yes ❑ No
Have pain with urination?	❑ Yes ❑ No
Have burning with urination?	❑ Yes ❑ No
Have blood in your urine?	❑ Yes ❑ No
Have to strain to empty your bladder?	❑ Yes ❑ No
Dribble after you empty your bladder?	❑ Yes ❑ No
Do you feel you still have urine in your bladder after urinating?	❑ Yes ❑ No

ABSORBENT PRODUCTS USED: (*indicate # used per day*)

Incontinence pad (poise, depends) _____
Incontinence brief _____
# of underwear changes _____
Do you soak the pad fully? ❑ Yes ❑ No
Do you change the pad each time it is wet? ❑ Yes ❑ No

OCCURRENCE OF INCONTINENCE OF LEAKAGE

- ❑ Never
- ❑ Less than 1/month
- ❑ More than 1/month
- ❑ Less than 1/week
- ❑ More than 1/week
- ❑ Almost every day
- ❑ More than 1/day # ___

SEVERITY

- ❑ No leakage
- ❑ Few drops
- ❑ Wet underwear
- ❑ Wet outerwear

POSITION OR ACTIVITY WITH LEAKAGE

- ❑ Lying down
- ❑ Sitting
- ❑ Standing
- ❑ Changing positions (from sit to stand)
- ❑ Intercourse
- ❑ Strong Urge

HOW LONG CAN YOU DELAY THE NEED TO URINATE?

- ❑ Indefinitely
- ❑ 1+ hours
- ❑ ½ hour
- ❑ 15 minutes
- ❑ Less than 10 minutes
- ❑ 1-2 minutes
- ❑ Not at all

ACTIVITY THAT CAUSES URINE LOSS

- ❑ Vigorous activity
- ❑ Moderate activity
- ❑ Light activity
- ❑ No activity

AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?

- ❑ Can stop completely
- ❑ Can maintain a deflection of the stream
- ❑ Can partially deflect the urine stream
- ❑ Unable to deflect or slow the stream

FREQUENCY OF URINATION (DAYTIME)
- ❑ 0 Times Per Day
- ❑ 1-4
- ❑ 5-8
- ❑ 9-12
- ❑ 13+

FREQUENCY OF URINATION (NIGHTTIME)
- ❑ 0 Times Per Night
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4+

DO YOU HAVE TROUBLE INITIATING A URINE STREAM?
- ❑ Never
- ❑ More than 1/month
- ❑ Less than 1/week
- ❑ Almost every day

ATTITUDE TOWARDS PROBLEM
- ❑ No problem
- ❑ Minor inconvenience
- ❑ Slight problem
- ❑ Moderate problem
- ❑ Major problem

CONFIDENCE IN CONTROLLING YOUR PROBLEM
- ❑ Complete confidence
- ❑ Moderate confidence
- ❑ Little confidence
- ❑ No confidence

BOWEL HABITS:

How often do you have a bowel movement? _____

Do you strain having a bowel movement?	❑ Yes	❑ No	
Do you experience abdominal cramping?	❑ Yes	❑ No	
Do you leak/stain feces?	❑ Yes	❑ No	If yes, how often? _____
Do you experience diarrhea?	❑ Yes	❑ No	If yes, How often? _____
Do you use laxatives?	❑ Yes	❑ No	If yes, how often/week? _____
Do you use enemas?	❑ Yes	❑ No	If yes, how often/week? _____
Do you include fiber in your diet daily?	❑ Yes	❑ No	If yes, how much? _____

FUNCTIONAL LIMITATIONS: (*check yes or no*)

Do you have difficulty:

Getting on/off the toilet?	❑ Yes	❑ No
Getting clothes on/off?	❑ Yes	❑ No
With toilet hygiene?	❑ Yes	❑ No
Getting out of bed?	❑ Yes	❑ No

Have you restricted your physical activities because of incontinence/pain?(exercise, walking, dancing, etc.)❑Yes ❑ No

If yes, please give specific examples _____

_____

_____

_____

_____

Have you restricted your social activities because of incontinence/pain? (Have to stay close to a bathroom, interrupted activities due to needing to go to the bathroom often, etc.) ❑ Yes ❑ No

If yes, please give specific examples _____

_____

_____

_____

_____

Have you had changes in intimate relationship/sexual functioning due to incontinence/pain? ❑ Yes ❑ No
If yes, please give specific examples _____
_____

Please circle the number on the scale below which best indicates the extent to which **incontinence** limits your daily life:

1	2	3	4	5	6	7	8	9	10
No limits									Severely Limiting

Please circle the number on the scale below which best indicates the extent to which **pain** limits your daily life:

1	2	3	4	5	6	7	8	9	10
No limits									Severely Limiting

Any comments or concerns not asked? _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____