PELVIC FLOOR THERAPY QUESTIONAIRRE

Name:_____

Date: _____

Symptom(s): Please circle which symptoms that apply

Urge Incontinence (Overactive Bladder) **Stress Incontinence**

Chronic Pelvic Pain **Erectile Dysfunction**

How long have you experienced the problem you have indicated above?

_____

How many times per day are you bothered by this condition?

_____

What actions or situations aggravate your symptoms?

_____

_____

What treatments have been used for this condition?

Surgery: _____

Other: _____

What Medications are you currently taking?

_____

_____

_____

For Incontinence patients:

Do you use a urinary control device? Yes No

If yes, how many devices per day? _____

What would you consider successful treatment?_____