Washington University Physicians®
Washington University School of Medicine in St. Louis

Women's Center for Bladder and Pelvic Health

Name:_____ Date of Birth:_____ Visit Date:_____

Please complete this questionnaire prior to arriving at the clinic so that we can be better prepared to address your particular health care needs. **Please note that pages are double sided.**

Provider who **referred** you:	Your **Primary Care Provider**:
Name_____	Name_____
Address_____	Address_____
City_____ State_____ Zip Code_____	City_____ State_____ Zip Code_____
Phone number:_____	Phone number:_____
Fax number:_____	Fax number:_____

Please list the name of your pharmacy:

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone number:_____

If you are cared for by a **cardiologist** please list below:	Please list the names and addresses of <u>any other doctor</u> you would like us to communicate with:
Name_____	Name_____
Address_____	Address_____
City_____ State____ Zip Code_____	City_____ State____ Zip Code_____
Phone number:_____	Phone number:_____
Fax number:_____	Fax number:_____

What is the **reason for your visit**?_____

_____

_____

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by putting an **X** in the appropriate box or boxes. While answering these questions, please consider your symptoms over the **last 3 months.**

Do you_____?		**If yes, how much does it bother you?** Not at all	Somewhat	Moderately	Quite a bit
Usually experience *pressure* in your lower abdomen?	☐ **Yes** ☐ **No**				
Usually experience *heaviness* or *dullness* in the pelvic area?	☐ **Yes** ☐ **No**				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	☐ **Yes** ☐ **No**				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	☐ **Yes** ☐ **No**				
Usually experience a feeling of incomplete bladder emptying?	☐ **Yes** ☐ **No**				
Ever have to push up on a bulge in the vaginal area with your fingers To start or complete urination?	☐ **Yes** ☐ **No**				
Have you ever tried using a pessary?	☐ **Yes** ☐ **No**				

Do you usually experience_____?		**If yes, how much does it bother you?** Not at all	Somewhat	Moderately	Quite a bit
frequent urination?	☐ **Yes** ☐ **No**				
urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	☐ **Yes** ☐ **No**				
urine leakage related to coughing, sneezing, or laughing?	☐ **Yes** ☐ **No**				
small amounts of urine leakage?	☐ **Yes** ☐ **No**				
difficulty emptying your bladder?	☐ **Yes** ☐ **No**				
pain or discomfort in the lower abdomen or genital region?	☐ **Yes** ☐ **No**				

Do you_____?		**If yes, how much does it bother you?** Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement?	☐ **Yes** ☐ **No**				
Feel you have not completely emptied your bowels at the end of a bowel movement?	☐ **Yes** ☐ **No**				
Usually lose stool beyond your control if your stool is well formed?	☐ **Yes** ☐ **No**				
Usually lose stool beyond your control if your stool is loose?	☐ **Yes** ☐ **No**				

Usually lose gas from the rectum beyond your control? ☐ **Yes** ☐ **No**					
Usually have pain when you pass your stool? ☐ **Yes** ☐ **No**					
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ **Yes** ☐ **No**					
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? ☐ **Yes** ☐ **No**					

Please list the things you are **allergic** to **AND** your reaction to it. Include medications, food, and environmental allergies. ☐ **I do not have any allergies**

Medicine/Food/Other Allergies:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever used any medicines to help control your bladder or bowels? List all that apply:_____

_____

☐ I have not used medications.

Please list the **medicines are you currently taking.** Include all over the counter **(OTC)** medications like vitamins, herbs, remedies and supplements.

Medicine/OTC Medicine	Dose	Medicine/OTC Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please answer the following questions about **urination:**

How frequently do you urinate during the day?	Every _____ hours	
How many times do you get up at night to urinate?	_____ times	
Do you ever wet the bed?	☐ Yes	☐ No
Do you feel you completely empty your bladder?	☐ Yes	☐ No
Do you have trouble starting your stream of urine?	☐ Yes	☐ No
Do you notice any change in your stream of urine?	☐ Yes	☐ No
Do you ever dribble urine?	☐ Yes	☐ No
Do you need to wear pads for protection from urine leakage?	☐ Yes	☐ No

Have you had 3 or more urinary tract infections in the past year?	☐ Yes	☐ No
Have you ever used a pessary for prolapse or incontinence?	☐ Yes	☐ No

On an average day, how much do you drink? List below.

Type of Fluid	Amount	Type of Fluid	Amount
Example: decaf coffee	*2 8oz cups*		

Please answer the following questions about your **OBSTETRICAL AND GYNECOLOGIC HISTORY:**

How many times have you been pregnant?		
How many children did you deliver?		
Of these, how many were delivered:	Vaginally:	By C-Section:
	Forcep Assisted? ☐ Yes ☐ No	Vacuum Assisted? ☐ Yes ☐ No
How big was your biggest baby?	_____lbs. _____oz.	
What was your age at each delivery?	_____	
Did you have any problems with any of your deliveries?	☐ Yes Explain:_____	☐ No

Have you experienced menopause?	
☐ **Yes – please answer questions 1-3 only**	☐ No – **please answer questions 4-7 only:**
1. How old were you when you went through menopause? _____ years old	4. Date of your Last Menstrual Period: _____
2. Do you take hormone replacements? ☐ Yes ☐ No	5. Periods come every _____days and lasts _____ days.
2a. If yes, list the type:_____	6. Do you have problems with your periods? ☐ Yes ☐ No
3. How long have you taken hormone replacement? _____years	7. Do you use Birth Control? ☐ Yes ☐ No If yes list method: _____

Are you sexually active?	☐ Yes	☐with men	☐with women	☐Not sexually active
Is sexual intercourse painful for you?	☐ Yes	☐ No		
Are you satisfied with your sexual function?	☐ Yes	☐ No		
Would you like to talk about it with your physician?	☐ Yes	☐ No		
Do you leak urine during intercourse?	☐ Yes	☐ No		
In your life, have you ever been sexually or physically abused?	☐ Yes	☐ No		
Have you ever had an abnormal Pap smear? Did you have to have treatment?	☐ Yes ☐ Yes	☐ No ☐ No	Date of last Pap smear: _____ What type?	
Have you had an abnormal mammogram?	☐ Yes	☐ No	Date of last mammogram:	

Have you ever had an abnormal colon screen?	☐ Yes	☐ No	Date of last colon screening: (colonoscopy or sigmoidoscopy)
Have you ever had pelvic radiation for any reason?	☐ Yes	☐ No	

Please answer these questions about your **MEDICAL HISTORY.**

Do you have any of the following conditions? Check all appropriate boxes.

Heart Problems	**Lung Problems**	**Bowel Problems**	**Neurologic Problems**
☐ Heart Disease	☐ Asthma	☐ Bowel Disease	☐ Parkinson's Disease
☐ High Blood Pressure	☐ Pneumonia	☐ Ulcers	☐ Multiple Sclerosis
☐ Heart Murmur	☐ Tuberculosis	☐ Diverticulitis	☐ Stroke
☐ Heart Attack	☐ Emphysema	☐ Liver disease	☐ Back injury, surgery, known herniated disc
☐ High Cholesterol/Lipids		☐ Diverticulosis	
Endocrine Problems	**Bleeding problems**	**Other**	
☐ Diabetes	☐ Bleeding problem	☐ Kidney Disease	
☐ Thyroid Disease	☐ Blood clot problem	☐ Arthritis	
☐ Osteoporosis	☐ Aspirin use	☐ Glaucoma	
☐ Chronic Steroid Use		☐ Cancer	

Please tell us more about anything that was checked above, or about any other problems:

_____

_____

_____

SURGICAL HISTORY

List **ALL surgeries you have had** and the approximate year:

Surgery	***Year***	***Surgery***	***Year***
☐ Appendectomy_____	_____	**Please List Any Other Surgeries Below:**	
☐ Tonsillectomy_____	_____	_____	_____
☐ Gallbladder surgery___	_____	_____	_____
☐ Knee replacement____	_____	_____	_____
☐ Cesarean deliver_____	_____	_____	_____
☐ Hysterectomy_____	_____	_____	_____

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how much your activities, relationships, or feelings are being affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions related to the following →→ usually affect your ↓	**Bladder or urine**	**Bowel or rectum**	**Pelvis or vagina**
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Frustration?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

DAILY ACTIVITIES

What kind of work do you do?_____

Do you exercise regularly? ☐ **Yes** ☐ **No** If yes, how many hours per week? _____

What types of exercise do you do?_____

Who is your main support person (partner, spouse, friend)?_____

Do you consider yourself healthy? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No How many packs a day?_____

Exposed to secondhand smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Starting at what age? _____

Ending at what age? _____ How many packs a day? _____

How many cans of beer_____, glasses of wine_____ , or alcohol _____(oz) do you drink every week?

FAMILY HISTORY

Please note if anyone in your family has a history of any of these diseases. **Please specify mother or father's side.**

			Family Member(s)
Breast Cancer	☐ Yes	☐ No	_____
Ovarian Cancer	☐ Yes	☐ No	_____
Other Cancer	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Urinary incontinence	☐ Yes	☐ No	_____

Other _____

	Age	Living	Deceased	State of Health (if deceased, cause of death)
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Are you **currently** having any problems with any of the following: (check all that apply)

Constitutional	Eyes	Gastrointestinal	Endo/Heme/Allergies
☐ Fever	☐ Blurred vision	☐ Heartburn	☐ Easy bruising
☐ Chills	☐ Double vision	☐ Nausea	☐ Environmental Allergies
☐ Weight loss	☐ Sensitivity to light	☐ Vomiting	☐ Excessive thirst
☐ Malaise/Fatigue/Tired	☐ Eye Pain	☐ Abdominal pain	**Neurological**
☐ Intense sweating	☐ Eye Discharge	☐ Diarrhea	☐ Dizziness
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Tingling
Skin		☐ Blood in stool	☐ Tremors/shaking
☐ Rash		☐ Black, tarry stool	☐ Sensory changes
Head/Ears/Nose/Throat	**Cardiovascular**	**Genitourinary**	☐ Speech changes
☐ Headache	☐ Chest pain	☐ Painful urination	☐ Focal weakness
☐ Hearing loss	☐ Heart palpitations	☐ Urgency	☐ Seizures
☐ Ringing in ears	☐ Shortness of breath when lying flat	☐ Frequency of urination	☐ Loss of consciousness
☐ Ear pain	☐ Cramps in lower legs	☐ Blood in urine	**Psychological**
☐ Nosebleeds	☐ Leg swelling		☐ Depression
☐ Congestion	**Respiratory**	**Musculoskeletal**	☐ Suicidal thoughts
☐ Sore throat	☐ Cough	☐ Muscle pain	☐ Substance abuse
	☐ Coughing up blood	☐ Neck pain	☐ Hallucinations
	☐ Excess sputum	☐ Back pain	☐ Nervousness/Anxiety
	☐ Shortness of breath	☐ Joint pain	☐ Insomnia
	☐ Wheezing	☐ Falls	☐ Memory Loss

NOTE: The rest of this packet contains questionnaires related to your body image and sexual activity. We realize these can be very sensitive topics, and do not want you to feel uncomfortable about answering these questions. We

feel that they will help us better understand how your symptoms may be impacting your quality of life, but your response is optional.

Instructions

Women who experience prolapse may have a variety of feelings about how the condition affects them. The following items are about how having prolapse may affect your feelings about yourself and your body. Please read each statement carefully and indicate whether you agree or disagree with the statement by checking the box next to the appropriate response. Some questions ask about how you may feel about your prolapse and your body in intimate situations with a partner. Please try to imagine how you would feel if you were in that situation and pick the answer that best fits how you think you would feel.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Because of my prolapse, I would worry that my partner might avoid being intimate with me.					
I would be embarrassed for my partner to touch my genitals due to my prolapse.					
I would avoid intimate situations or sexual activity with my partner because of my prolapse.					
Because of my prolapse, I would become anxious in intimate situations.					
I feel less attractive due to my prolapse.					
I feel less feminine due to my prolapse.					
I feel less confident about my body due to my prolapse.					
My prolapse affects how I feel about the rest of my body.					
I would try to hide my prolapse from my partner during intimate situations.					
I feel older than my age due to my prolapse.					

Pelvic Organ Prolapse Incontinence Sexual Questionnaire IUGA-revised (PISQ-IR)

Q1 Which of the following best describes you:

Not sexually active at all 1 ☐ → **Go to item Q2 (Section 1)**

Sexually active with or without a partner 2 ☐ → **Skip to item Q7 (Section 2)**

Section 1: If you are NOT sexually active complete Q2-Q6
If you engage in sexual activity please check this box and skip to next page and answer Q7-Q20

Q2 The following are a list of reasons why you might not be sexually active, for each one please indicate how strongly you agree or disagree with it as a reason that you are not sexually active.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. No partner				
b. No Interest				
c. Due to bladder or bowel problems (urinary or fecal incontinence) or due to prolapse (a feeling of or a bulge in the vaginal area)				
d. Because of my other health problems.				
e. Pain				

Q3 How much does the fear of leaking urine and/or stool and/or a bulging in the vagina (either the bladder, rectum or uterus falling out) cause you to avoid or restrict your sexual activity?

1 ☐ Not at All 2 ☐ A Little 3 ☐ Some 4 ☐ A Lot

Q4 For each of the following, please circle the number between 1 and 5 that best represents how you feel about your sex life.

a.	Satisfied	1	2	3	4	5	Dissatisfied
b.	Adequate	1	2	3	4	5	Inadequate

Q5 How strongly do you agree or disagree with each of the following statements:

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. I feel frustrated by my sex life				
b. I feel sexually inferior because my incontinence and/or prolapse				
c. I feel angry because of the impact that incontinence and/or prolapse has on my sex life				

Q6 Overall, how bothersome is it to you that you are not sexually active?

1 ☐ Not at All 2 ☐ A Little 3 ☐ Some 4 ☐ A Lot

THANK YOU

End of Items for Not Sexually Active

Section 2: **For Those Who are Sexually Active**
The remaining items in the survey are about a topic that one is not often asked to report on in a survey please answer as honestly and clearly as you possibly can.

Q7 How often do you feel sexually aroused (physically excited or turned on) during sexual activity?

1 ☐ Never 3 ☐ Sometimes 5 ☐ Always
2 ☐ Rarely 4 ☐ Usually

Q8 When you are involved in sexual activity, how often do you feel each of the following:

	Never	Rarely	Sometimes	Usually	Almost Always
a. Fulfilled					
b. Shame					
c. Fear					

Q9 How often do you leak urine and/or stool with <u>any type</u> of sexual activity?

1 ☐ Never 3 ☐ Sometimes 5 ☐ Always
2 ☐ Rarely 4 ☐ Usually

Q10 Compared to orgasms you have had in the past, how intense are your orgasms now?

1 ☐ Much less intense 3 ☐ Same intensity 5 ☐ Much more intense
2 ☐ Less intense 4 ☐ More intense

Q11 How often do you feel pain during sexual intercourse? (If you don't have intercourse check this box and skip to the next item.)

1 ☐ Never 3 ☐ Sometimes 5 ☐ Always
2 ☐ Rarely 4 ☐ Usually

Q12 Do you have a sexual partner? 1 ☐ Yes → **Go to Q13** 2 ☐ No → **Skip to Q15**

Q13 How often does your partner have a problem (lack of arousal, desire, erection, etc.) that limits your sexual activity?

1 ☐ All of the time 2 ☐ Most of the time 3 ☐ Some of the time 4 ☐ Hardly ever/Rarely

Q14 In general, would you say that your partner has a positive or negative impact on each of the following:

	VERY POSITIVE	SOMEWHAT POSITIVE	SOMEWHAT NEGATIVE	VERY NEGATIVE
a. Your sexual desire	☐ 1	☐ 2	☐ 3	☐ 4
b. The frequency of your sexual activity	☐ 1	☐ 2	☐ 3	☐ 4

Q15 When you are involved in sexual activity, how often do you feel that you want more?

1 ☐ Never
2 ☐ Rarely
3 ☐ Sometimes
4 ☐ Usually
5 ☐ Always

Q16 How frequently do you have sexual desire, this may include wanting to have sex, having sexual thoughts or fantasies, etc.?

1 ☐ Daily
2 ☐ Weekly
3 ☐ Monthly
4 ☐ Less than once a Month
5 ☐ Never

Q17 How would you rate your level (degree) of sexual desire or interest?

1 ☐ Very high
2 ☐ High
3 ☐ Moderate
4 ☐ Low
5 ☐ Very low or none at all

Q18 How much does the fear of leaking urine, stool and/or a bulging in the vagina (prolapse) cause you to avoid sexual activity?

1 ☐ Not at all 2 ☐ A Little 3 ☐ Some 4 ☐ A Lot

Q19 For each of the following, please circle the number between 1 and 5 that best represents how you feel about your sex life.

a. Satisfied	1	2	3	4	5	Dissatisfied
b. Adequate	1	2	3	4	5	Inadequate
c. Confident	1	2	3	4	5	Not Confident

Q20 How strongly do you agree or disagree with each of the following statements:

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. I feel frustrated by my sex life				
b. I feel sexually inferior because of my incontinence and/or prolapse.				
c. I feel embarrassed about my sex life				
d. I feel angry because of the impact that incontinence and/or prolapse has on my sex life				

THANK YOU