

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: _____

| | |
|---|--|
| <p>If you are cared for by a cardiologist please list below:</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip Code _____</p> <p>Phone number: _____</p> <p>Fax number: _____</p> | <p>Please list the names and addresses of <u>any other doctor</u> you would like us to communicate with:</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip Code _____</p> <p>Phone number: _____</p> <p>Fax number: _____</p> |
|---|--|

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 <i>pressure</i> in your lower abdomen? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Usually experience <i>heaviness</i> or <i>dullness</i> in the pelvic area? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Usually have a bulge or something falling out that you can see or feel in your vaginal area? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Ever have to push on the vagina or around the rectum to have or complete a bowel movement? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Usually experience a feeling of incomplete bladder emptying? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Have you ever tried using a pessary? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Do you usually experience _____?

If yes, how much does it bother you?

Not at all Somewhat Moderately Quite a bit

| | | | | |
|--|--|--|--|--|
| frequent urination? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| urine leakage related to coughing, sneezing, or laughing? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| small amounts of urine leakage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| difficulty emptying your bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| pain or discomfort in the lower abdomen or genital region? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Feel you have not completely emptied your bowels at the end of a bowel movement? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Usually lose stool beyond your control if your stool is well formed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Usually lose stool beyond your control if your stool is loose? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

| | | | | | |
|--|--|--|--|--|--|
| Usually lose gas from the rectum beyond your control? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Usually have pain when you pass your stool? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel you completely empty your bladder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble starting your stream of urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you notice any change in your stream of urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you ever dribble urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you need to wear pads for protection from urine leakage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had 3 or more urinary tract infections in the past year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever used a pessary for prolapse or incontinence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

| Type of Fluid | Amount | Type of Fluid | Amount |
|------------------------------|-------------------|---------------|--------|
| <i>Example: decaf coffee</i> | <i>2 8oz cups</i> | | |
| | | | |
| | | | |

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? <input type="checkbox"/> Yes <input type="checkbox"/> No | Vacuum Assisted? <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes Explain: _____ | <input type="checkbox"/> No |

Have you experienced menopause?

| <input type="checkbox"/> Yes – please answer questions 1-3 only | <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Periods come every _____ days and lasts _____ days. |
| 2a. If yes, list the type: _____ | 6. Do you have problems with your periods? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. How long have you taken hormone replacement? _____ years | 7. Do you use Birth Control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes list method: _____ |

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

| | | | |
|--|------------------------------|-----------------------------|--|
| Have you ever had an abnormal colon screen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date of last colon screening: (colonoscopy or sigmoidoscopy) |
| Have you ever had pelvic radiation for any reason? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Back injury, surgery, known herniated disc |
| <input type="checkbox"/> High Cholesterol/Lipids | | <input type="checkbox"/> Diverticulosis | |
| Endocrine Problems | Bleeding problems | Other | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood clot problem | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Aspirin use | <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> Chronic Steroid Use | | <input type="checkbox"/> 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 |
| <input type="checkbox"/> Appendectomy_____ | _____ | Please List Any Other Surgeries Below: | |
| <input type="checkbox"/> Tonsillectomy_____ | _____ | _____ | _____ |
| <input type="checkbox"/> Gallbladder surgery____ | _____ | _____ | _____ |
| <input type="checkbox"/> Knee replacement_____ | _____ | _____ | _____ |
| <input type="checkbox"/> Cesarean deliver_____ | _____ | _____ | _____ |
| <input type="checkbox"/> 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)? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| 2. Ability to do physical activities such as walking, swimming, or other exercise? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| 3. Entertainment activities such as going to a movie or concert? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| 4. Ability to travel by car or bus for a distance greater than 30 minutes away from home? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| 5. Participating in social activities outside your home? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| 6. Emotional health? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit |
| 7. Frustration? | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> 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.**

| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <u>Family Member(s)</u> |
|----------------------|------------------------------|-----------------------------|-------------------------|
| Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ovarian Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Urinary incontinence | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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

[Click here if you are having NONE of the above symptoms](#)

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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, page 11)**

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 choose 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

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your computer**

