LAFAYETTE Rehabilitation Services
A UNITY HEALTHCARE PARTNER

WOMEN'S HEALTH THERAPY QUESTIONNAIRE

NAME: _____ **PHYSICIAN:** _____ **DATE:** _____

Please describe your main problem: _____

When did it begin? **Is it getting:** **better** **worse** **staying the same** (circle one)

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

_____

Please describe list all pelvic and abdominal surgeries with dates of operation: _____

Date of last pelvic exam: _____ **Number of Pregnancies:** _____ **Complications:** _____

Do you have pain or problems with sexual activity or urination? Describe: _____

_____

PLEASE CIRCLE ANSWERS BELOW AS THEY APPLY TO YOU

OCCURRENCE OF INCONTINENCE OR LEAKAGE	never	less than 1/month	more than 1/month	less than 1/week	more than 1/week	____ leaks per day
PROTECTION WORN	no protection	Panti-shields	Mini Pads	Maxi Pads	Diapers/Serenity	
SEVERITY	no leakage	few drops	wet underwear	wet outerwear		
ATTITUDE TOWARDS PROBLEM	no problem	minor inconvenience	slight problem	moderate problem	major problem	
POSITION OR ACTIVITY WITH LEAKAGE	lying down	sitting	standing	changing positions	sexual activity	strong urge
HOW LONG CAN YOU DELAY THE NEED TO URINATE	indefinitely	1+ hours	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	other:_____	
PROLAPSE (falling out feeling)	never	occasionally w/ menses	pressure at end of the day	pressure with straining	pressure with standing	perineal pressure all day
FREQUENCY OF URINATION – DAYTIME	0	1-4	5-8	9-12	13+	
FREQUENCY OF URINATION – NIGHTTIME	0	1	2	3	4+	
WHEN URINATING, CAN YOU COMPLETELY STOP THE FLOW	can stop completely	can maintain a defection of the stream	can partially deflect the urine stream	unable to deflect or slow the urine stream		
FLUID INTAKE (includes water & beverages)	1-2 8oz glasses/day	3-5 8oz glasses/day	6-8 8oz glasses/day	9+ 8oz glasses/day	how many caffeinated glasses/day? _____	

PLEASE USE THE BACK OF THIS PAPER TO LIST ANY ADDITIONAL SYMPTOMS OR PROBLEMS RELATED TO YOUR VISIT.

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