Female pelvic floor symptom survey form

This form is for patients who are receiving treatment at the Turku university hospital's Department of Obstetrics and Gynecology. It has sections which must be filled by hand and it should be printed.

Name: _____

National insurance number: _____ Date: _____/ _____ 20_____

1.Do you experience urinary incontinence?

Yes ____ No ____

Answer the questions by circling your answer.	**0**	**1**	**2**
How many times you urinate during the day?	5—7	8—10	11
How many times you need to get up to urinate during the night?	0—1	2—3	4—
Is there still urine in the bladder after urinating?	No	At times	Often
Does stress or anxiety cause a strong urge to urinate?	No	Mild urge	Strong urge
Do you leak urine when you experience physical strain (for example coughing)?	Yes	At times	At times even without strain
Does the urine leak occur immediately when the strain begins?	Immedi-ately	Not sure	After the strain
Do you feel urge to urinate before urine starts leaking?	No	At times	Often
How much urine leaks each time?	Drops	A small amount	My bladder empties
Can you stop urinating mid-stream?	Yes	Fairly well	No
Have you had urinary tract infections within the last 2 years? How many?	None	1 to 2	3 or more

Differential diagnosis (doctor fills in): >8 rakon instabiliteetti, <6 ponnistusinkontinenssi (_____)

	0	1	2
Do you leak urine when not performing strenuous activity and regardless of position (for example when lying down)?	No	At times	Very often
Do you leak urine when you perform non-strenuous activities (for example when getting up)?	No	At times	Very often
Do you leak urine when there is sudden strenuous activity (for example when sneezing or running)?	No	At times	Very often
Do you leak urine when there is sudden strenuous activity (for example when sneezing or running)?	No	At times	Very often
Do the symptoms interfere with your everyday chores?	No	At times	Very often
Do these symptoms impair your ability to work?	No	At times	Very often
Are you afraid that other people notice the smell and wetness caused by leaking urine?	No	At times	Very often
Do the symptoms interfere with your hobbies and activities?	No	At times	Very often
Do the symptoms affect your sex life?	No	At times	Very often
Do you experience irritation in your outer genitals?	No	At times	Very often
Are you forced to use pads or diapers?	No	At times	Very often

Degree of disability (doctor fills in): >10 huomattava haitta, <5 intensiivihoito ei perusteltua

(_____)

In your opinion, how negatively urinary incontinence affects your life?

Mark X on the line: ●----------●

Not at all Very negatively

2. Do you experience bowel incontinence?

Yes ____ No ____

Answer the questions below by marking your answer with an X.

	0 Never	**1 Less than once a month**	**2 Every month**	**3 Every week**	**4 Every day**
Do you experience unintentional leaking of solid stool?					
Do you experience unintentional leaking of loose stool?					
Do you pass gas without meaning to?					
Do you use a pad because of the bowel incontinence?					
Does the bowel incontinence impair your quality of life and social life?					

Wexner score (doctor fills in): ≥ 9 heikentää elämänlaatua (_____)

In your opinion, how negatively bowel incontinence affects your life?

Mark X on the line: ●----------●

Not at all Very negatively

3. Do you have constipation or difficulty passing bowel movements?

Yes ___ No ___

Answer the questions below by marking your answer with an X.

	Yes	No
I have less than three bowel movements a week		
I use laxatives or stool softeners		
My stools are hard		
I do not feel the urge to have a bowel movement		
I have to strain considerably when I pass a bowel movement		
I feel like there is an obstruction when I try to pass a bowel movement		
I need to have multiple bowel movements in a row and stool remains in the rectum		
I need to use my fingers to press on the rectum from the outside, or to dig out/remove stool		

Drossman criteria positive (doctor fills in):

Ulostaminen ≤ 3 x vrk +/- ponnistus yli ¼ ulostamisajasta **(____)**

In your opinion, how negatively difficulties passing bowel movements affects your life?

Mark X on the line: ●----------●

Not at all Very negatively

4. Does pelvic floor dysfunction limit your sex life?

Yes ___ No ___ I do not want this to be mentioned ___

5. Do you have a protrusion / prolapse? Yes ___ No ___

My most pressing issue is (circle your answer)

Urinary incontinence Bowel incontinence

constipation or difficulty passing bowel movements protrusion/prolapse

Other problems:_____

_____