Female Symptom Monitor

Name: _____ Date: _____

Occupation: _____ Age: _____

Complaints: 1. _____

2. _____

3. _____

When did this start: _____

Gynecological History:

pregnancies: ___ # live births: ___ Wt. heaviest baby: ___ lbs ___ oz Length pushing stage: ___ hours

Forceps? ☐ Yes ☐ No Episiotomies? ☐ Yes ☐ No Tears? ☐ Yes ☐ No

HRT? ☐ Yes ☐ No When? _____ Last pap: _____ Normal? ☐ Yes ☐ No

Sexually Active? ☐ Yes ☐ No Pain with sex? ☐ Yes ☐ No When? ☐ Penetration ☐ Thrusting?

Birth Control Method: _____ C-Section: ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No If yes, ☐ Trouble falling to sleep? ☐ Trouble Staying Asleep?

Do you have feelings of heaviness or pressure in your vagina? ☐ Yes ☐ No

Has anyone ever told you that you have a prolapse? ☐ Yes ☐ No

Surgical History:

Abdominal: ☐ When: _____

Pelvic: ☐ When: _____

Bladder Symptoms: Please put an X next to the statements that best describe your symptoms:

My incontinence is associated with activities such as sneezing, running or laughing ☐ daily ☐ weekly
S

My leakage occurs after having a strong voiding sensation that feels uncontrollable ☐ daily ☐ weekly
U

I void during the day more than the average person (>5-7 X/day) _____ # times per day
F

My bladder troubles cause me to go to the bathroom at night _____ # times/night
N

My bladder problems cause me to leak at night _____ # times/week
N

My incontinence requires me to wear pads _____ # pads/day

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When I void I don't empty completely and feel like I have to go again soon ☐ Yes ☐ No ☐ Sometimes

R

I have pain when I urinate ☐ Yes ☐ No ☐ Sometimes

PBS

I have to strain when I urinate ☐ Yes ☐ No ☐ Sometimes

TP

I have leakage during intercourse ☐ Yes ☐ No ☐ Sometimes

S

I had problems with my bladder during my childhood ☐ Yes ☐ No

I feel overwhelmingly strong sensations prior to voiding but I don't leak ☐ Yes ☐ No

U

Fluid Intake in 24 hours:

#____cups of coffee/day #____cups of water/day #____cups of tea/day # _____ cups of other fluids/day

Bowel History:

Frequency: /week

Fecal Incontinence: ☐ Yes ☐ No Stool Consistency:
☐ Loose ☐ Soft/formed ☐ Hard ☐ Varies

Fecal Urgency: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

Medical History:

Urinary Tract Infections: ☐ Yes ☐ No Antibiotics Recently? ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No ____ #packs/day

Chronic Cough: ☐ Yes ☐ No

Do you get blood in your urine: ☐ Yes ☐ No

Allergies (including latex): _____

Height: ____ ft. ____ In. Weight: _____ lbs BMI: _____(therapist)

Back Problems: ☐ Yes ☐ No

If yes, please ask the receptionist for the Pelvic Girdle Assessment Form

Neck Problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

On a scale from 1-10, please circle and rate your current pain/discomfort

1 2 3 4 5 6 7 8 9 10

DASS Questionnaire

Name: _____ Date: _____

Please read each statement and circle a number, o, 1, 2, or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all
1 = Applied to me to some degree or some of the time
2 = Applied to me a considerable degree, or a good part of the time
3 = Applied to me very much, or most of the time

I find it hard to wind down……	S	0	1	2	3
I was aware of dryness of my mouth……	A	0	1	2	3
I could not seem to experience any feeling at all……	D	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness					
In the absence of physical exertion……	A	0	1	2	3
I found it difficult to work up the initiative to do things……	D	0	1	2	3
I tended to over-react to situations……	S	0	1	2	3
I experienced trembling (e.g. hands)……	A	0	1	2	3
I felt that I was using a lot of nervous energy……	S	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself…..	A	0	1	2	3
I felt that I had nothing to look forward to……	D	0	1	2	3
I found myself getting agitated……	S	0	1	2	3
I found it difficult to relax……	S	0	1	2	3
I felt down-hearted and blue……	D	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing….	S	0	1	2	3
I felt I was close to panic……	A	0	1	2	3
I was unable to become enthusiastic about anything……	D	0	1	2	3
I felt I was not much of a person……	D	0	1	2	3
I felt that I was rather touchy……	S	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g.					
Sense of heart rate increase, heart missing a beat)……	A	0	1	2	3
I felt scared without any good reason……	A	0	1	2	3
I felt that life was meaningless……	D	0	1	2	3

Urogenital Distress Inventory

*(**Reference:** Uebersax, J.S., Wyman, J.F., Shumaker, S.A., McClish, D.K., Fantl, J.A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. Neurology and Urodynamics, 14(2), 131-139.)*

Name: _____ Date: _____

1.	Do you usually experience frequency urination? If yes, how much does this bother you? ○ Yes ○ No	○ Not at all (0) ○ Somewhat (1) ○ Moderately (2) ○ Quite a bit (3)
2.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom? If yes, how much does this bother you? ○ Yes ○ No	○ Not at all (0) ○ Somewhat (1) ○ Moderately (2) ○ Quite a bit (3)
3.	Do you usually experience urine leakage related to coughing, sneezing or laughing? If yes, how much does this bother you? ○ Yes ○ No	○ Not at all (0) ○ Somewhat (1) ○ Moderately (2) ○ Quite a bit (3)
4.	Do you experience small amounts of urine leakage (drops)? If yes, how much does this bother you? ○ Yes ○ No	○ Not at all (0) ○ Somewhat (1) ○ Moderately (2) ○ Quite a bit (3)
5.	Do you experience difficulty emptying your bladder? If yes, how much does this bother you? ○ Yes ○ No	○ Not at all (0) ○ Somewhat (1) ○ Moderately (2) ○ Quite a bit (3)
6.	Do you usually experience pain or discomfort in the lower abdominal genital region? If yes, how much does this bother you? ○ Yes ○ No	○ Not at all (0) ○ Somewhat (1) ○ Moderately (2) ○ Quite a bit (3)

If yes, is your pain relieved after emptying your bladder?

○ Yes
○ No

Total Score ___/6 _____

X 33.3 = Final Score: _____

Scoring: Add the total score. Calculate the average. Multiply the average by 33 1/3 to put scores on a scale of 0 to 100.

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