FEMALE SYMPTOM MONITOR

Name: _____ Date: _____

Occupation: _____ Age: _____

Complaints: 1. _____

2. _____

3. _____

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 every 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

(Reference: Loribond et al. The structure of negative emotional states; comparison of the DASS with the Beck Inventories. Beh. Res. Ther 1995; 33:335-342)

Please read each statement and circle a number, 0, 1, 2 or 3, which indicates how much the statement applied to *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

0…..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 found 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. in the 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 worth much as 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

S = ____ A =____ D =____

Assessment Symptom Outcome Measure

The following questions are reproduced with permission from the International Pelvic Pain Society, www.pelvicpain.org

Please read each of the following statements and circle the number that best represents your symptoms:

0 = no pain 1 = mild pain 2 = mild-moderate pain 3 = moderate4 = moderate-severe 5 = severe symptoms

Pain:						
How would you rate your present pain……	0	1	2	3	4	5
Pain when lifting……	0	1	2	3	4	5
Pain when sitting……	0	1	2	3	4	5
Pain when walking……	0	1	2	3	4	5
Pain while doing physical activity……	0	1	2	3	4	5
Deep pain with sexual intercourse or sexual activity……	0	1	2	3	4	5
Pelvic pain lasting hours or days after sexual activity……	0	1	2	3	4	5
Pain when bladder when full……	0	1	2	3	4	5
Pain with urination……	0	1	2	3	4	5
Muscle or joint pain……	0	1	2	3	4	5
Abdominal pain……	0	1	2	3	4	5
Backache……	0	1	2	3	4	5
Pain when wearing tight clothing……	0	1	2	3	4	5
Pain with bowel movement……	0	1	2	3	4	5
Pain after bowel movement……	0	1	2	3	4	5
A falling-out feeling or a feeling of pressure in the pelvis……	0	1	2	3	4	5
Bladder Symptoms:	0	1	2	3	4	5
Loss of urine when coughing, sneezing, lifting or laughing……	0	1	2	3	4	5
Frequency of urination versus the normal of once every 2-3 hours……	0	1	2	3	4	5
Urgency or need to urinate with little warning……	0	1	2	3	4	5
Loss of urine due to strong urge……	0	1	2	3	4	5
Difficulty initiating urine stream……	0	1	2	3	4	5
Urine stream stops and starts……	0	1	2	3	4	5
Nighttime urinary frequency……	0	1	2	3	4	5
Incomplete emptying of urine……	0	1	2	3	4	5
Bowel Symptoms:	0	1	2	3	4	5
Constipation (fewer than 3 bowel movements/week)……	0	1	2	3	4	5
Bowel frequency (more than 3 bowel movements/day)……	0	1	2	3	4	5
Incomplete emptying of bowel……	0	1	2	3	4	5
Urgency or need to have a bowel movement with little warning……	0	1	2	3	4	5
Abdominal bloating or fullness……	0	1	2	3	4	5
Lumpy or hard stool consistency……	0	1	2	3	4	5
Needing to strain to achieve bowel movement……	0	1	2	3	4	5
Fecal incontinence……	0	1	2	3	4	5

Since your symptoms began, how much as your lifestyle been affected?
0 = no effect **1** = mild affect **2** = mild-moderate affect **3** = moderate affect **4** = moderate-severe **5** = substantive change

Effect on Daily Life:

Symptoms or pain limits or interferes with work or school……	0	1	2	3	4	5
Symptoms or pain limits or interferes with social activities……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with exercise routine……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with lifting, cleaning, carrying, etc……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with recreational/athletic activities……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with sexual activity……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with sleep……..	0	1	2	3	4	5
Symptoms or pain cause unexplained mood changes……..	0	1	2	3	4	5
Pain at ovulation (mid-cycle)……..	0	1	2	3	4	5
Pain level just before period……..	0	1	2	3	4	5
Pain (not cramps) with period……..	0	1	2	3	4	5
Cramps with your period……..	0	1	2	3	4	5
Pain after period is over……	0	1	2	3	4	5
Burning vaginal pain with penetration of tampon or during sex……	0	1	2	3	4	5
Difficulty achieving orgasm (even when aroused)……	0	1	2	3	4	5

Total: _____ / 245