

NAME: _____

DATE OF BIRTH: _____

APFI FEMALE PELVIC FLOOR QUESTIONNAIRE

MAIN PROBLEM: _____ DURATION: _____

OTHER PROBLEM/S: _____ TION: _____

BLADDER SECTION

<p>URINARY FREQUENCY How many times do you pass urine in the day?</p> <p><input type="checkbox"/> up to 7 <input type="checkbox"/> between 8-10 <input type="checkbox"/> between 11-15 <input type="checkbox"/> more than 15</p>	<p>NOCTURIA How many times do you get up at night to pass urine?</p> <p><input type="checkbox"/> 0-1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> more than 3 times</p>	<p>NOCTURNAL ENURESIS Do you wet the bed before you wake up?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - less than 1/ week <input type="checkbox"/> frequently - 1 or more/week always <input type="checkbox"/> every night</p>
<p>URGENCY Do you need to rush/ hurry to pass urine when you get the urge?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - < 1/week <input type="checkbox"/> frequently - > 1/week <input type="checkbox"/> daily</p>	<p>URGE INCONTINENCE Does urine leak when you rush/hurry to the toilet/ Can you make it in time?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - < 1/week <input type="checkbox"/> frequently - > 1/week <input type="checkbox"/> daily</p>	<p>STRESS INCONTINENCE Do you leak with coughing, sneezing, laughing, exercising?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - < 1/week <input type="checkbox"/> frequently - > 1/week <input type="checkbox"/> daily</p>
<p>WEAK STREAM Is your urinary stream/ flow weak/prolonged/ slow?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - < 1/week <input type="checkbox"/> frequently - > 1/week <input type="checkbox"/> daily</p>	<p>INCOMPLETE BLADDER EMPTYING Do you have a feeling of incomplete bladder emptying?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - < 1/week <input type="checkbox"/> frequently - > 1/week <input type="checkbox"/> daily</p>	<p>PAD USAGE Do you have to wear pads?</p> <p><input type="checkbox"/> none - 1 as a precaution <input type="checkbox"/> with exercise/ during a cold <input type="checkbox"/> daily</p>
<p>REDUCED FLUID INTAKE Do you limit your fluid intake to decrease leakage?</p> <p><input type="checkbox"/> never <input type="checkbox"/> before going out/ socially <input type="checkbox"/> moderately <input type="checkbox"/> daily</p>	<p>RECURRENT UTI Do you have frequent bladder infections?</p> <p><input type="checkbox"/> no <input type="checkbox"/> 1 to 3/per year <input type="checkbox"/> 4 to 12/per year <input type="checkbox"/> more than one per month</p>	<p>DYSURIA Do you have pain in your bladder/urethra when you empty your bladder?</p> <p><input type="checkbox"/> never <input type="checkbox"/> occasionally - < 1/week <input type="checkbox"/> frequently - > 1/week <input type="checkbox"/> daily</p>

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IMPACT ON SOCIAL LIFE

Does urine leakage affect your routine activities (recreation, shopping etc.)

- not at all
- slightly
- moderately
- greatly

HOW MUCH OF A BOTHER

Is your bladder problem to you?

- no problem
- slightly
- moderately
- greatly

Other symptoms

(haematuria, pain etc.)

BOWEL SECTION

DEFAECATION FREQUENCY

How often do you usually open your bowels?

- < 1/week
- < every 3 days
- >3/week or daily
- >more than 1/day

CONSISTENCY OF BOWEL MOTION

How is the consistency of your usual stool?

- soft
- firm
- hard/pebbles
- watery
- variable
- daily

DEFAECATION STRAINING

Do you have to strain a lot to empty your bowels?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

LAXATIVE USE

Do you use laxatives to empty your bowels?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

DO YOU FEEL CONSTIPATED?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

FLATUS INCONTINENCE

When you get wind/ flatus, can you control it or does wind leak?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

FAECAL URGENCY

Do you get an overwhelming sense of urgency to empty bowels?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

FAECAL INCONTINENCE WITH DIARRHOEA

Do you leak watery stool when you don't mean to?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

FAECAL INC. WITH NORMAL STOOL

Do you leak normal stool when you don't mean to?

- never
- occasionally-< 1/week
- frequently -> 1/week
- daily

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<p>INCOMPLETE BOWEL EVACUATION Do you have the feeling of incomplete bowel emptying?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally—< 1/week</p> <p><input type="checkbox"/> frequently -> 1/week</p> <p><input type="checkbox"/> daily</p>	<p>OBSTRUCTED DEFECATION Do you use finger pressure to help empty your bowel?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally—< 1/week</p> <p><input type="checkbox"/> frequently -> 1/week</p> <p><input type="checkbox"/> daily</p>	<p>HOW MUCH OF A BOTHER is your bowel problem to you?</p> <p><input type="checkbox"/> no problem</p> <p><input type="checkbox"/> slightly</p> <p><input type="checkbox"/> moderately</p> <p><input type="checkbox"/> greatly</p>
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Other symptoms
(problems sitting/walking, pain, vag. ...)

PROLAPSE SECTION

<p>PROLAPSE SENSATION Do you get a sensation of tissue protrusion in your vagina/lump/bulging?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally—< 1/week</p> <p><input type="checkbox"/> frequently -> 1/week</p> <p><input type="checkbox"/> daily</p>	<p>VAGINAL PRESSURE OR HEAVINESS Do you experience vag. pressure/ heaviness/ dragging sensation?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally—< 1/week</p> <p><input type="checkbox"/> frequently -> 1/week</p> <p><input type="checkbox"/> daily</p>	<p>PROLAPSE REDUCTION TO VOID Do you have to push back your prolapse in order to void?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally—< 1/week</p> <p><input type="checkbox"/> frequently -> 1/week</p> <p><input type="checkbox"/> daily</p>
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<p>PROLAPSE REDUCTION TO DEFAECATE Do you have to push back your prolapse to empty your bowels?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally—< 1/week</p> <p><input type="checkbox"/> frequently -> 1/week</p> <p><input type="checkbox"/> daily</p>	<p>HOW MUCH OF A BOTHER is the prolapse to you?</p> <p><input type="checkbox"/> no problem</p> <p><input type="checkbox"/> slightly</p> <p><input type="checkbox"/> moderately</p> <p><input type="checkbox"/> greatly</p>
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Other symptoms
(problems sitting/walking, pain, vag. ...)

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SEXUAL FUNCTION SECTION

<p>SEXUALLY ACTIVE? Are you sexually active?</p> <p><input type="checkbox"/> no</p> <p><input type="checkbox"/> < 1/week</p> <p><input type="checkbox"/> >1/week</p> <p><input type="checkbox"/> most days / daily</p>	<p>IF NOT, WHY NOT:</p> <p><input type="checkbox"/> no partner</p> <p><input type="checkbox"/> partner unable</p> <p><input type="checkbox"/> vaginal dryness</p> <p><input type="checkbox"/> too painful</p> <p><input type="checkbox"/> embarrassment</p> <p><input type="checkbox"/> other</p>	<p>SUFFICIENT LUBRICATION Do you have sufficient lubrication during intercourse?</p> <p><input type="checkbox"/> no</p> <p><input type="checkbox"/> yes</p>
<p>DURING INTERCOURSE VAGINAL SENSATIONIS:</p> <p><input type="checkbox"/> none</p> <p><input type="checkbox"/> painful</p> <p><input type="checkbox"/> minimal</p> <p><input type="checkbox"/> normal /pleasant</p>	<p>VAGINAL LAXITY Do you feel that your vagina is too loose or lax?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally</p> <p><input type="checkbox"/> frequently</p> <p><input type="checkbox"/> always</p>	<p>VAGINAL TIGHTNESS/ VAGINISMUS Do you feel that your vagina is too tight</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally</p> <p><input type="checkbox"/> frequently</p> <p><input type="checkbox"/> always</p>
<p>DYSPAREUNIA Do you experience pain with intercourse:</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally</p> <p><input type="checkbox"/> frequently</p> <p><input type="checkbox"/> always</p>	<p>DYSPAREUNIA WHERE Where does the pain occur</p> <p><input type="checkbox"/> no pain</p> <p><input type="checkbox"/> at the entrance of the vagina</p> <p><input type="checkbox"/> deep inside/ in the pelvis</p> <p><input type="checkbox"/> both</p>	<p>COITAL INCONTINENCE Do you leak urine during sex?</p> <p><input type="checkbox"/> never</p> <p><input type="checkbox"/> occasionally</p> <p><input type="checkbox"/> frequently</p> <p><input type="checkbox"/> always</p>
<p>HOW MUCH OF A BOTHER Are these sexual issues to you?</p> <p><input type="checkbox"/> not applicable</p> <p><input type="checkbox"/> no problem at all</p> <p><input type="checkbox"/> slight problem</p> <p><input type="checkbox"/> moderate problem</p> <p><input type="checkbox"/> great problem</p>		

Other symptoms
(coital flatus or faecal incontinence,