



THE WOMAN'S CENTER FOR ADVANCED PELVIC SURGERY

Specializing in Pelvic Floor Disorders, Urinary Incontinence & Pelvic Organ Prolapse

Pelvic Floor Distress Inventory - Short Form 20

INSTRUCTIONS

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer these questions by putting a **X** in the appropriate box or boxes. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months**.

EXAMPLE

For the following question:

If you do not usually have headaches just put an **X** in the 'No' box

Do you usually experience *headaches*?

No; Yes

If yes, how much does this bother you?

1 2 3 4
Not at all - Somewhat - Moderately - Quite a bit

If you do usually have headaches, put an X in the 'Yes' box and indicate how much the headaches bother you. (In this example, the headaches were *moderately* bothersome)

Do you usually experience *headaches*?

No; Yes

If yes, how much does this bother you?

1 2 3 4
Not at all - Somewhat - Moderately - Quite a bit

Patient Name: _____

Appt. Date: _____

1. Do you usually experience *pressure* in the lower abdomen?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

2. Do you usually experience *heaviness* or *dullness* in the pelvic area?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

Patient Name: _____

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6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4
Not at All - Somewhat - Moderately - Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4
Not at All - Somewhat - Moderately - Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4
Not at All - Somewhat - Moderately - Quite a bit

9. Do you usually lose stool beyond your control if your stool is well formed?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4
Not at All - Somewhat - Moderately - Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4
Not at All - Somewhat - Moderately - Quite a bit

Patient Name: _____

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11. Do you usually lose gas from the rectum beyond your control?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4

Not at All - Somewhat - Moderately - Quite a bit

12. Do you usually have pain when you pass your stool?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4

Not at All - Somewhat - Moderately - Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4

Not at All - Somewhat - Moderately - Quite a bit

14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4

Not at All - Somewhat - Moderately - Quite a bit

15. Do you usually experience frequent urination?

No; Yes

0

If yes, how much does this bother you?

1 2 3 4

Not at All - Somewhat - Moderately - Quite a bit

Patient Name: _____

Appt. Date: _____

16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

18. Do you usually experience small amounts of urine leakage (that is, drops)?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

19. Do you usually experience difficulty emptying your bladder?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit

20. Do you usually experience pain or discomfort in the lower abdomen or genital region?

No; Yes

0

If yes, how much does this bother you?

1 **2** **3** **4**

Not at All - Somewhat - Moderately - Quite a bit



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INSTRUCTIONS

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. You may or may not have symptoms in each of these three areas, but please be sure to mark an answer in **all 3 columns** for each question. If you do not have symptoms in one of these areas, then the appropriate answer would be “Not at all” in the corresponding column for each question.

EXAMPLE

For the following question:

If your bladder symptoms interfere with your ability to drive a car *moderately*, and your bowel symptoms interfere with your ability to drive a car *somewhat*, but your vaginal or pelvic symptoms do not interfere with your ability to drive a car or you have no vaginal or pelvic symptoms then you should place an **X** in the corresponding boxes as indicated below:

How do symptoms or conditions related to the following →→→→ usually affect your ↓	<i>Bladder or Urine</i>	<i>Bowel or Rectum</i>	<i>Vagina or Pelvis</i>
1. ability to drive a car	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input checked="" type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input checked="" type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input checked="" type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

Please make sure to answer all 3 columns for each and every question.

Thank you for your cooperation.

Patient Name: _____

Appt Date: _____

Pelvic Floor Impact Questionnaire – short form 7

Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please be sure to mark an answer in **all 3 columns** for each question. Thank you for your cooperation.

How do symptoms or conditions related to the following →→→→ usually affect your ↓	<i>Bladder or Urine</i>	<i>Bowel or Rectum</i>	<i>Vagina or Pelvis</i>
1. ability to do household chores (cooking, housecleaning, laundry)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
2. ability to do physical activities such as walking, swimming or other Exercise?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
3. entertainment activities such as going to a movie or concert?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
4. ability to travel by car or bus for a distance greater than 30 minutes away from home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
5. participating in social activities outside your home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
6. emotional health (nervousness, depression, etc)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
7. feeling frustrated?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

Patient Name: _____

Appt. Date: _____



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Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the past six months. Thank you for your help.

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.
 Always (0) Usually (1) Sometimes (2) Seldom (3) Never (4)
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?
 Always (0) Usually (1) Sometimes (2) Seldom (3) Never (4)
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?
 Always (0) Usually (1) Sometimes (2) Seldom (3) Never (4)
4. How satisfied are you with the variety of sexual activities in your current sex life?
 Always (0) Usually (1) Sometimes (2) Seldom (3) Never (4)
5. Do you feel pain during sexual intercourse?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
6. Are you incontinent of urine (leak urine) with sexual activity?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
10. Does your partner have a problem with erections that affects your sexual activity?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?
 Always (4) Usually (3) Sometimes (2) Seldom (1) Never (0)
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?
 Much less intense (4) Less intense (3) Same intensity (2) More intense (1) Much more intense (0)