

Bladder Habits

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| 1. Are you unable to stop the flow of urine when on the toilet? | Y/N |
| 2. Is it difficult to tell when you need to go to the toilet? | Y/N |
| 3. Do you strain to pass urine? | Y/N |
| 4. Do you empty your bladder before you experience the urge to urinate? | Y/N |
| 5. Do you have difficulty completely emptying your bladder? | Y/N |
| 6. Do you have difficulty initiating the stream of urine? | Y/N |
| 7. Do you have triggers that make you feel you can not wait to use the toilet? | Y/N |
| 8. Do you have pain or burning with urination? | Y/N |
| 9. Do you have pain or discomfort when you wipe yourself? | Y/N |
| 10. Do you leak more during, before or after your period? | Y/N |

Bowel Habits

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| 1. Are you unable to feel that you need to have a bowel movement or pass gas? | Y/N |
| 2. Do you strain to have a bowel movement? | Y/N |
| 3. Do you feel your rectum is not completely empty after a bowel movement? | Y/N |
| 4. Do you have difficulty initiating a bowel movement? | Y/N |
| 5. Do you have pain or burning with bowel movements? | Y/N |
| 6. Do you have a history of hemorrhoids? | Y/N |
| 7. Have you experienced a change in your bowel habits? | Y/N |
| If 'yes', please describe _____ | |
| 8. Do you take anything to help you pass your stool? | Y/N |
| If 'yes', please list _____ | |
| 9. Do you have difficulty holding back gas? | Y/N |

Pelvic Floor Symptoms

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| 1. Are you sexually active? | Y/N |
| 2. Do you have pain with intercourse or penetration? | Y/N |
| 3. Do you have pain with use of tampons? | Y/N |