Piedmont HealthCare
Women's Center

Please fill out the following Pelvic Health Questionnaire to help us better serve your needs

Name: _____ Doctor: _____

- ☐ Frequent Urination
- ☐ Leaking when Sneezing, Coughing, Exercise
- ☐ Sudden and strong urge to urinate
- ☐ Waking at night to urinate

1. *Do you experience any of the below symptoms? (Please check all that apply)*

- ☐ Unable to make it to the bathroom in time
- ☐ Feeling or inability to empty bladder
- ☐ None of the symptoms

2. *If you experience leaking how often does it occur?*

- ☐ Daily
- ☐ Multiple times a day
- ☐ Weekly
- ☐ Very infrequent

3. *How do your symptoms affect your quality of life?*

- ☐ No affect
- ☐ Minor but acceptable
- ☐ Affects daily routine
- ☐ Majorly affects quality

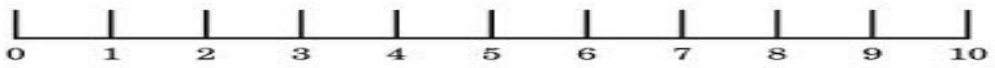
4. *Do you have any problems with bowel function?*

- ☐ Bowel Incontinence
- ☐ Constipation
- ☐ Straining
- ☐ Other

5. *Do you experience any pelvic pain?*

- ☐ Yes
- ☐ No

6. *On a scale of 1-10, rate your typical pelvic pain or discomfort. 0= No pain 10= Highest*



7. *Do you have any pain associated with bowel movements or bladder function?*

- ☐ Yes
- ☐ No

8. *Do you experience any of the following symptoms?*

- ☐ Vaginal Dryness
- ☐ Pain with intercourse
- ☐ Vaginal Pain
- ☐ Lower back pain

9. *How do your symptoms affect your quality of life?*

- ☐ No affect
- ☐ Minor but acceptable
- ☐ Affects daily routine
- ☐ Majorly affects quality

10. *Does anyone in your family have a history of endometriosis?*

- ☐ Yes
- ☐ No