Pelvic Health Symptom Monitor

What is the reason for booking this consult?

When did this start?

Gynecological history

What age did your period start?

Is your cycle regular?

- ◯ No
- ◯ Yes

How long is your cycle?

Do you suffer from PMS?

- ◯ No
- ◯ Yes

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Do you suffer from PMS?

- ◯ No
- ◯ Yes

Is your bleeding heavy?

- ◯ No
- ◯ Yes

Is your bleeding heavy?

- ◯ No
- ◯ Yes

Do you have pain with your period?

- ◯ No
- ◯ Yes

If yes, where?

Do you use tampons?

- ◯ No
- ◯ Yes

Do you have pain with insertion of a tampon?

- ◯ No
- ◯ Yes

Do you have excessive discharge?

- ◯ No
- ◯ Yes

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Are you sexually active?

- ◯ No
- ◯ Yes

Do you use birth control?

- ◯ No
- ◯ Yes

If yes, what type?

Do you experience pain with intercourse?

- ◯ No
- ◯ Yes

Number of pregnancies

Number of live births

Weight of heaviest baby

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Length of active stage of labor in hours ('pushing' stage)

Number of C-sections

Number of vaginal deliveries

Did you have an epidural?

- ◯ No
- ◯ Yes

Did you have a vacuum-assisted delivery?

- ◯ No
- ◯ Yes

Forceps?

- ◯ No
- ◯ Yes

Episiotomies?

- ◯ No
- ◯ Yes

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Tears?

- ◯ No
- ◯ Yes

During my labour(s) and delivery, I felt supported and cared for:

- ◯ All or most of the time
- ◯ Some of the time
- ◯ A little bit
- ◯ Not at all

Were there times during labour and delivery that you were (or thought you were) in danger of death or injury?

- ◯ No
- ◯ Yes

Were there times when the baby was or seemed to be in danger during labour and delivery?

- ◯ No
- ◯ Yes

Do you suffer/have you suffered from post-partum depression?

- ◯ No
- ◯ Yes

Have you gone through menopause?

- ◯ No
- ◯ Yes

If yes, when?

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Do you suffer from vaginal dryness?

- ◯ No
- ◯ Yes

Have you had hormone replacement therapy?

- ◯ No
- ◯ Yes

If yes, what?

Do you use lubrication?

- ◯ No
- ◯ Yes

If yes, what type?

Do you suffer from vaginal dryness?

- ◯ No
- ◯ Yes

Do you have feelings of heaviness/pressure in your vagina?

- ◯ No
- ◯ Yes

Have you ever been told you have a prolapse?

- ◯ No
- ◯ Yes

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Have you had any of the following medical procedures? If so, please provide approximate date

- [ ] Appendectomy
- [ ] Bartholin Cyst
- [ ] Bowel resection
- [ ] Laparoscopy
- [ ] Cystoscopy
- [ ] Colostomy
- [ ] TVT-TVT(O)
- [ ] Gallbladder removal
- [ ] Hemorrhoid surgery
- [ ] Mesh procedure
- [ ] Prolapse/Vaginal repair
- [ ] Hysterectomy

Please provide approximate date for any above procedures you have checked off.

Do you suffer from vaginal dryness?

- ◯ No
- ◯ Yes

Do you have feelings of heaviness/pressure in your vagina?

- ◯ No
- ◯ Yes

Have you ever been told you have a prolapse?

- ◯ No
- ◯ Yes

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Bladder symptoms

Did you have problems with your bladder during childhood?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have leakage associated with sneezing, coughing, running and/or laughing?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have leakage during intercourse?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you feel really strong sensations prior to voiding but don't leak?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Does your leakage occur after having a strong urge that feels uncontrollable?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have pain when your bladder fills?

- ◯ No
- ◯ Yes
- ◯ Sometimes

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Does your pain improve when you void?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have pain when you void?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have to strain in order to empty your bladder?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have difficulty starting your urine steam?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you have dribbling after you get up from the toilet?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do you sit on the toilet?

- ◯ No
- ◯ Yes
- ◯ Sometimes

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Do you have incomplete emptying when you void and feel like you have to go again soon?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Do your bladder problems cause you to leak at night?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Does your incontinence fluctuate with your cycle?

- ◯ No
- ◯ Yes
- ◯ Sometimes

Does your incontinence require you to wear pads?

- ◯ No
- ◯ Yes
- ◯ Sometimes

If yes or sometimes, how often?

Do you void during the day more than the average person (5-7x/day)?

- ◯ No
- ◯ Yes
- ◯ Sometimes

If yes or sometimes, how often?

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Do you need to get up at night to void?

- ◯ No
- ◯ Yes
- ◯ Sometimes

If yes or sometimes, how often?

Fluid intake in 24 hours

How many cups of water do you drink per day?

How many cups of coffee do you drink per day?

How many cups of tea do you drink per day?

How many cups of other fluids do you drink per day?

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How many cups of alcoholic drinks do you drink per day?

Digestion & bowel function

What is the frequency of your bowel movements?

Do you regularly feel the urge to move your bowels?

- Always
- Seldom
- Never

Do you have constipation?

- Always
- Seldom
- Never

Do you strain to have a bowel movement?

- Always
- Seldom
- Never

Do you have loose stools/diarrhea?

- Always
- Seldom
- Never

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Do you have bowel urgency that is difficult to control?

- ◯ Always
- ◯ Seldom
- ◯ Never

Do you lose control of your bowels?

- ◯ Always
- ◯ Seldom
- ◯ Never

Do you have incomplete emptying?

- ◯ Always
- ◯ Seldom
- ◯ Never

Do you have pain with a bowel movement?

- ◯ Always
- ◯ Seldom
- ◯ Never

Do you have pain after a bowel movement?

- ◯ Always
- ◯ Seldom
- ◯ Never

Does it take longer than 5 minutes to have a bowel movement?

- ◯ Always
- ◯ Seldom
- ◯ Never

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Do you have bloating? (Increased pressure in abdomen)

- ◯ Always
- ◯ Seldom
- ◯ Never

Do you experience a physical change in abdominal girth when your bowels are full (distension)?

- ◯ Always
- ◯ Seldom
- ◯ Never

In your opinion, is your fibre intake:

- ◯ Too low
- ◯ Adequate
- ◯ Too high

Do you regularly use?

- ☐ Laxatives
- ☐ Stool softeners
- ☐ Natural products
- ☐ Enemas

Have you ever been diagnosed with/think you have (if so, include when and who provided the diagnosis)

- ☐ Irritable bowel syndrome
- ☐ Ulcerative colitis
- ☐ Crohn's Disease
- ☐ Celiac Disease

Please provide more details for any of the above you've checked off.

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Do you have any food allergies or sensitivities?

Medical history

Do you suffer from urinary tract infections?

- ◯ No
- ◯ Yes

If yes, how often?

Have you taken any antibiotics recently?

- ◯ No
- ◯ Yes

Probiotics?

- ◯ No
- ◯ Yes

Cranberry supplementation?

- ◯ No
- ◯ Yes

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Smoking?

- ◯ No
- ◯ Yes

If yes, # packs/day

Chronic cough?

- ◯ No
- ◯ Yes

Yeast infection?

- ◯ No
- ◯ Yes

If yes, how often?

When was your last infection?

What was the treatment for your last infection?

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Do you get blood in your urine?

- ◯ No
- ◯ Yes

List your allergies, including latex:

Do you exercise?

- ◯ No
- ◯ Yes

If yes, what type and how often?

Do you have low back problems?

- ◯ No
- ◯ Yes, but not chronic
- ◯ Yes, and it is chronic

Have you ever been treated for depression?

- ◯ No
- ◯ Yes

If yes, what treatment?

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Is/was the treatment effective?

- ◯ No
- ◯ Yes

Have you ever been treated for anxiety?

- ◯ No
- ◯ Yes

If yes, what treatment?

Is/was the treatment effective?

- ◯ No
- ◯ Yes

On a scale from 1-10, please place a check in the circle to rate how much this problem bothers you:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

On a scale from 1-10, please place a check in the circle to rate how motivated you are to correct this problem:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10