Pelvic Health Screening (PHS)

Please read each statement and check YES if it applies to you or NO if it does not. If you are filling this out on a follow-up visit only, please rate how much each symptom you check YES to has improved on a scale from 0-10, where 0 is no change since beginning treatment, and 10 is full resolution of the symptom.

Do you urinate more than 8 times a day?

- ◯ No
- ◯ Yes

Do you have difficulty initiating urination?

- ◯ No
- ◯ Yes

Do you have burning with urination?

- ◯ No
- ◯ Yes

Do you feel that your bladder is not emptied after you have urinated?

- ◯ No
- ◯ Yes

Do you experience any urine or fecal leakage or loss (on way to bathroom, coughing/sneezing, or exercising?

- ◯ No
- ◯ Yes

Do you experience painful intercourse?

- ◯ No
- ◯ Yes

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Do you have less than one bowel movement every 3 days?

- ◯ No
- ◯ Yes

Do you have to strain or facilitate to have a bowel movement?

- ◯ No
- ◯ Yes

Do you have pain during or after a bowel movement?

- ◯ No
- ◯ Yes

Do you experience pelvic pain and/or pelvic pressure, i.e. vaginal, rectal, penile, testicular, bladder, tailbone or pelvic girdle?

- ◯ No
- ◯ Yes