



Male Incontinence and/or Pelvic Pain Questionnaire

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Briefly describe your current complaint:

When did this problem begin? _____ Is it getting better _____ worse _____ same _____

Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10

0 = not a problem 10 = major problem

Rate the following statement as it applies to you today: 0 1 2 3 4 5 6 7 8 9 10

“My bladder is controlling my life.” 0 = not true at all 10 = completely true

Surgical History:

Have you had surgery for your back/spine, brain, pelvic organs, bladder, prostate, or abdominal organs? Y/N If yes to these or any other surgeries, please describe:

Do you now have or do you have a history of the following? Explain any checked responses and include dates when possible.

- | | |
|--|---|
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Low back pain/sciatica | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema/bronchitis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fecal incontinence |
| <input type="checkbox"/> Childhood bladder problems | <input type="checkbox"/> Smoking habit |
| <input type="checkbox"/> Trouble holding back gas | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Constant dribbling of urine | <input type="checkbox"/> Trouble feeling bladder fullness |
| <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Bladder cancer |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Joint problems | |

Bowel Habits:

of bowel movements per day? 0-1 1-2 2-3 >3 per week? 1-3 3-5 5-9 9-12 >12

Consistency of stool: Loose Normal Hard Do you ignore the urge to defecate? Y / N

Do you have trouble getting to the toilet in time? Y / N



Bladder Habits:

Number of times you urinate during the day?	3-5	6-9	10-13	>13
Number of times you urinate after going to bed?	0	1-2	2-3	>3
Y/N Do you take your time to empty your bladder?	Y/N	Does your bladder feel full after urination?		
Y/N Can you stop the flow of urine?	Y/N	Do you have a slow, hesitant urine stream?		
Y/N Do you strain to pass urine?	Y/N	Do you have "triggers" that make you feel you can't wait to urinate?		
Y/N Do you strain to pass feces?	Y/N			
Y/N Do you empty your bladder frequently, before the urge?				

Fluid Intake per day (one glass is 8 oz or one cup):	1-2	2-3	3-4	4-5	>5
Number of Caffeinated glasses per day:	0	1-2	2-3	3-4	4-5 >5
Number of Alcoholic glasses per day:	0	1-2	2-3	3-4	4-5 >5

Urine / Fecal Leakage Questions:

Number of urinary leakages daily:	1	2	3	4	5	>5
Number of fecal/bowel leakages daily:	1	2	3	4	5	>5
Severity of Leakage:	None	Few drops	Wets underwear		Wets outerwear	
Protection worn:	No protection			Full adult undergarment		
	Mini-pad			Waterproof underpants		
	Maxi-pad					

Position or Activity with Leakage:

Vigorous activity	Strong urge to go
Light activity	Intercourse or Sexual activity
Changing positions	No activity changes leakage (constant)
Walking to toilet	

Pelvic Pain Questions:

Circle appropriate answer(s): "I have pain with..."

Sexual intercourse	Standing
Urination	Tight clothes
Defecation	Ejaculation / Orgasm
Sitting	

Circle appropriate answer(s): "Pain is located..."

Deep	Rectum
Surface	Tailbone / Coccyx
Penis	Tailbone / Sacrum
Urethra	Pubic bone
Anus	Right side / Left side / Both sides



Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to Sovereign Rehabilitation for evaluation and treatment of pelvic floor dysfunction. I understand that to evaluate and treat my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length.

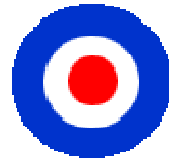
I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Sovereign Rehabilitation.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

Signature of parent or guardian (if applicable): _____



International prostate symptom score (IPSS)

Name:

Date:

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	Your score
Nocturia Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	
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Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6



Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.