Adventure Core
Nutrition and Fitness

PELVIC FLOOR DYSFUNCTION QUESTIONNAIRE (FEMALES)

1.	Do you have difficulty controlling your bowel, wind or urinary urges or leaking? YES, please give further details.	Yes?	No?
2.	Do you lose urinary control when laughing, sneezing, coughing or jumping?	Yes?	No?
3.	Are your bowel movements or urination painful? If YES, please give further details	Yes?	No?
4.	Do you experience a sensation of pressure in your vagina or rectum or noticed any protrusions from your orifices? Has anyone ever said you may have a prolapse? If YES, please give further details.	Yes?	No?
5.	Do you experience pain with intercourse or sexual stimulation? If YES, please give details.	Yes?	No?
6.	Do you currently or have you ever needed to wear incontinence pads?	Yes?	No?
7.	Do you experience pain in your genitals? If YES, please give details.	Yes?	No?
8.	Do you experience pain inside your pelvis? If YES, please give details.	Yes?	No?
9.	Are you currently pregnant?	Yes?	No?
10.	Have you recently (or ever) had a baby? Do you have a separation of your abdominal muscles at the midline?	Yes?	No?
11.	Are you going through or have been through the menopause?	Yes?	No?
12.	Have you ever undergone any gynecological surgery (eg.,a hysterectomy, fibroids removal?)	Yes?	No?
13.	Are you or have you ever been an elite athlete? Runner, gymnast, trampolining or any sport that involved regular contact?	Yes?	No?
14.	Do you have a history of low back pain?	Yes?	No?
15.	Have you ever sustained an injury to your pelvic region (fracture, radiotherapy or injury to your coccyx?)	Yes?	No?
16.	Do you suffer from constipation or regularly strain on the toilet? Do you need to assist your own voiding?	Yes?	No?
17.	Do you or have you ever had a chronic cough or a condition that affected your breathing (smoking, hay fever, asthma?)	Yes?	No?

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18.	Are you or have you been overweight?	Yes?	No?
19.	Do you frequently lift heavy weights? (Gym, work, children, caring for disabled or elders?)	Yes?	No?
20.	Are you incontinent overnight?	Yes?	No?
21.	Do you get up at night to go to the bathroom? If yes, how many times?	Yes?	No?
22.	Do you ever have accidental leakage of urine associated with a sudden strong urge to urinate or do you have trouble reaching the toilet in time?	Yes?	No?
23.	Do you ever have accidental leakage of urine during activities such as coughing, sneezing, laughing, running, exercising, or lifting	Yes?	No?

How often do you urinate during the day? (Circle one)			
Every 30 mins – 1 hour	Every 1-2 hours	Every 2-4 hours	Every 4+ hours

Notes:

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