University of South Florida, Tampa
USF Urogynecology and Reconstructive Surgery

(813) 447-1618

A. Patient History

1. Appointment Date: ____/____/_____ 2. ID:_____
3. Patient name: Last _____First_____ 4. Birth Date:_____/_____/_____

5. Date of last visit: _____
6. Surgery date (leave blank if you did not have surgery): _____

7. If you had surgery, which procedure did you have? _____

C. Urogyn

Genitourinary

1. In a typical day, how many times do you urinate?: (***frequency***) _____
2. In a typical night, how many times do you awaken to urinate?: (***nocturia***) _____
3. Do you leak urine when you do not want to (***SUI***)?: ☐ No ☐ Yes *If yes, check any conditions that cause you to leak:*

3a. ☐ Coughing ☐ Sneezing ☐ Laughing ☐ Exercise ☐ Upon standing
☐ Housework ☐ Lifting ☐ Intercourse

4. In a typical day, do you experience frequent, strong urges to urinate?: (***urgency***) ☐ No ☐Yes
4a. *If yes, do you leak urine during these strong urges: (**urge incontinence**)* ☐ No ☐Yes
5. In a typical week, do you have **difficulty emptying your bladder**?: ☐ No ☐Yes
6. Do you wear **pads**: ☐ No ☐Yes:
6a. *If yes, how many pads do you wear per day?*_____
7. How much fluids do you drink in a typical day? (***fluid intake***)_____
8. Please list any **overactive bladder medicines** you have tried and duration of use?_____
_____

Gastrointestinal

9. In a typical week, how many **bowel movements** do you have?: _____
10. In a typical week, how many **laxatives** do you use?: _____
11. In a typical week, do you have **difficulty having bowel movements**?: ☐ No ☐Yes
12. In a typical week, do you leak stool when you do not want to?: (***fecal incontinence***) ☐ No ☐Yes
13. In a typical week, do you leak gas when you do not want to?: (***flatal incontinence***) ☐ No ☐Yes

Gynecologic

14. Do you feel that your bladder, uterus, vagina or rectum are falling out?: (***prolapse symptoms***) ☐ No ☐Yes
15. Are you currently **sexually active**?: ☐ No ☐Yes
15a. Do you have any **physical problems** with sexual relations?: ☐ No ☐Yes
15b. Do you have pain with sexual intercourse?: (***dyspareunia***) ☐ No ☐Yes

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Urinary Questionnaire I (MESA)

Instructions:

These questions ask about symptoms you may have related to urine leakage. Please indicate the response that best represents how frequently you experience each symptom by placing an "X" under the appropriate response..

Part I: (Stress Symptoms)

	Never	Rarely	Sometimes	Often
Does coughing gently cause you to lose urine?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				
Does walking briskly or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?				
Does getting up from a sitting to a standing position cause you to lose urine?				

During the last **7 days**, how many times did you accidentally leak urine when you were performing some physical activity such as coughing, sneezing, lifting or exercise? # of times _____

Urinary Questionnaire I (MESA)

Instructions:

These questions ask about symptoms you may have related to urine leakage. Please indicate the response that best represents how frequently you experience each symptom by placing an "X" under the appropriate response..

Part II: (Urge Symptoms)

	Never	Rarely	Sometimes	Often
Some women receive very little warning and suddenly find that they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				
	Never	Rarely	Sometimes	Often
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
	Never	Rarely	Sometimes	Often
Do you lose urine when you suddenly have he feeling that your bladder is very full?				
	Never	Rarely	Sometimes	Often
Does washing your hands cause you to lose urine?				
	Never	Rarely	Sometimes	Often
Does cold weather cause you to lose urine?				
	Never	Rarely	Sometimes	Often
Does drinking cold beverages cause you to lose urine?				
	Never	Rarely	Sometimes	Often
During the last 7 days, how many times did you accidentally leak urine when you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?				

# of times in the past 7 days? _____

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Pelvic Floor Questionnaire (PFDI)

Instructions:

Please answer the following questions by placing an "X" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last three months**. Thank you for your help.

Date: _____ / _____ / _____

		No	Yes		Not at all	Somewhat	Moderately	Quite a bit
1	Do you usually experience *pressure* in the lower abdomen?	0		If yes, how much does this bother you?	1	2	3	4
2	Do you usually experience *heaviness or dullness* in the pelvic area?	0		If yes, how much does this bother you?	1	2	3	4
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	0		If yes, how much does this bother you?	1	2	3	4
4	Do you usually have to push on the vagina or around the rectum to have or complete bowel movement?	0		If yes, how much does this bother you?	1	2	3	4
5	Do you usually experience a feeling of incomplete bladder emptying?	0		If yes, how much does this bother you?	1	2	3	4
6	Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0		If yes, how much does this bother you?	1	2	3	4
7	Do you feel you need to strain too hard to have a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
8	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
9	Do you usually lose stool beyond your control if your stool is well formed?	0		If yes, how much does this bother you?	1	2	3	4
10	Do you usually lose stool beyond your control if your stool is loose or liquid?	0		If yes, how much does this bother you?	1	2	3	4

		No	Yes		Not at all	Somewhat	Moderately	Quite a bit
11	Do you usually lose gas from the rectum beyond your control?	0		If yes, how much does this bother you?	1	2	3	4
12	Do you usually have pain when you pass your stool?	0		If yes, how much does this bother you?	1	2	3	4
13	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
14	Does a part of your bowel every pass through the rectum and bulge outside during or after a bowel movement?	0		If yes, how much does this bother you?	1	2	3	4
15	Do you usually experience frequent urination?	0		If yes, how much does this bother you?	1	2	3	4
16	Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	0		If yes, how much does this bother you?	1	2	3	4
17	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0		If yes, how much does this bother you?	1	2	3	4
18	Do you usually experience small amounts of urine leakage (that is, drops)?	0		If yes, how much does this bother you?	1	2	3	4
19	Do you usually experience difficulty emptying your bladder?	0		If yes, how much does this bother you?	1	2	3	4
20	Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0		If yes, how much does this bother you?	1	2	3	4

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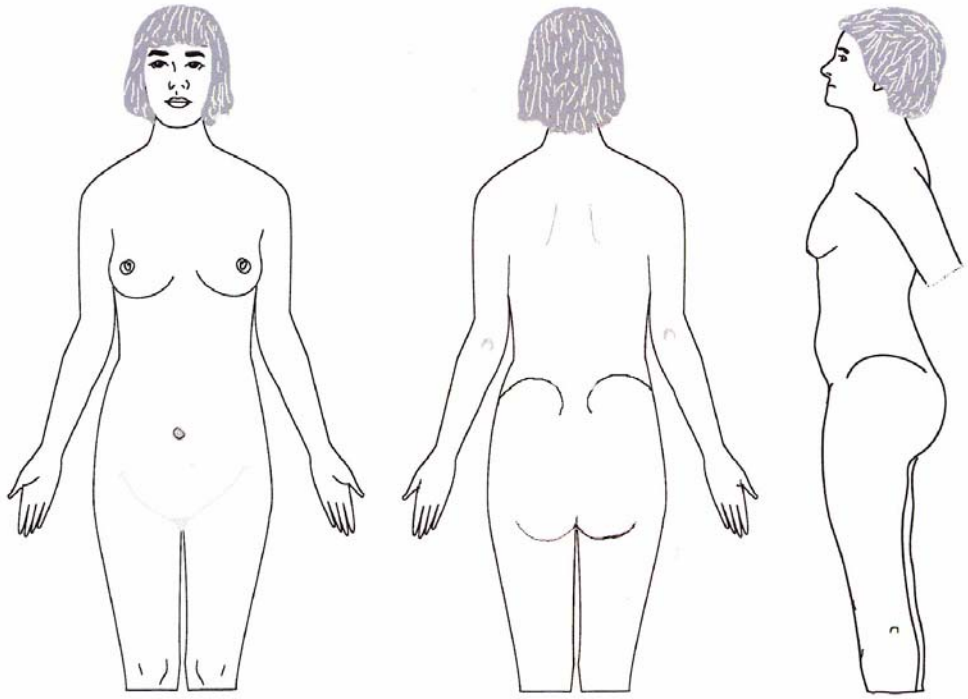
Pain worksheet: ***Instructions:***

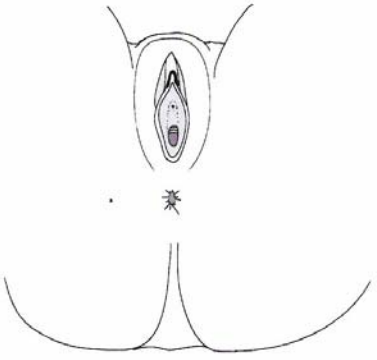
Please indicate the location(s) on the body maps below by marking, or circling the appropriate spot(s) in response to the following questions:

Are you in any pain or discomfort right now? If yes, please complete the area below.

Pain level (please circle) 0 - no pain 1 2 3 4 5 6 7 8 9 10 – worst pain of my life
Please mark the location of pain below with an "X"

Discomfort level 0 - no discomfort 1 2 3 4 5 6 7 8 9 10 – worst discomfort of my life
Please mark the location of discomfort below with a "O"





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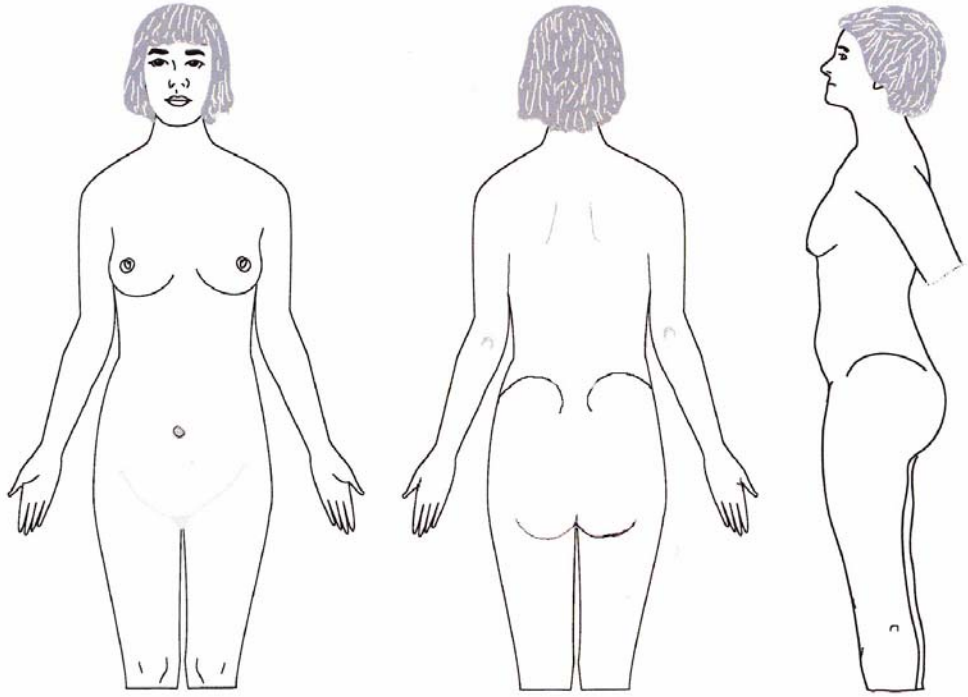
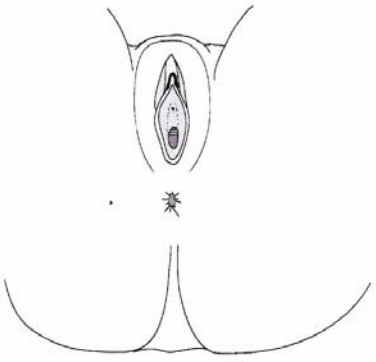
Bladder sensation worksheet: Instructions:

Please indicate the location(s) on the body maps below by placing and "X" or circling the appropriate spot(s) in response to the following question:

When you feel an urge to empty your bladder, where in your body is that urge located? (please circle the area where you feel the urge)





The Pelvic Pain and Urinary/Frequency (PUF) Patient Symptom Scale

Please circle the answer that best describes how you feel for each question.

	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3–6	7–10	11–14	15–19	20+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? Yes ___ No ___							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain, is it usually...		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually...		Mild	Moderate	Severe			
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
					Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a) =		
					Bother Score (2b, 4b, 7b, 8b) =		
					Total Score (Symptom Score + Bother Score) =		

813-447-1618

Pelvic Floor Questionnaire (PFIQ-7)

Instructions:

Some women find tht bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, plan an **"X"** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions ***over the last 3 months***.

How do symptoms or conditions related to the following usually affect your?

1. Ability to do household chores (cooking, housecleaning, laundry)?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

2. Ability to do physical activities such as walking, swimming or other exercise?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

3. Entertainment activities such as going to a movie or concert?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

5. Participating in social activities outside your home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

6. Emotional health (nervouseness, depression, etc.)?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

7. Feeling frustrated?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

For Clinic Use

	Mean Bladder/Urine (UIQ-7) (0,1,2,3)
	Mean Colorectal-Anal (CRAIQ-7)
	Mean Vagina/Pelvis (POPIQ-7)
	Scale Bladder/Urine (UIQ-7 *33.33))
	Scale Colorectal-Anal (CRAIQ-7 * 33.33)
	Scale Vagina/Pelvis (POPIQ-7* 33.33)
	PFIQ-7 Summary (=UIQ+CRAIQ+POPIQ)

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You are almost finished with the questionnaire!
Only 2 pages left

The next pages ask questions about your sex life. The questions are designed to help us better understand how your symptoms are affecting your quality of life.

.
If you ***are sexually active and wish to complete the questionnaire***, please continue on to the next page.

If you ***have not been sexually active in the past 3 months***, please mark an **X** in the space below, and ignore all questions beyond this page.

_____ I am not sexually active

If you ***do not wish*** to answer questions about your sexual activity, please mark an X in the space below, and ignore all questions beyond this page.

_____ I do not wish to answer any questions about my sexual activity.

Thank you,

The USF Urogynecology and Pelvic Surgery team

813-447-1618

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Instructions:

Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help us understand what is important to you about your sex life. Please check an (X) the box that best answers the question for you. While answering the questions, consider *your* sexuality over the past six months.

How do symptoms or condition related to the following usually affect your?

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.

Always (4)	Usually	Sometimes	Seldom	Never (0)

2. Do you climax (have an orgasm) when having ***sexual intercourse*** with your partner?

Always (4)	Usually	Sometimes	Seldom	Never (0)

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

Always(4)	Usually	Sometimes	Seldom	Never (0)

4. How satisfied are you with the variety of sexual activities in you current sex life?

Always (4)	Usually	Sometimes	Seldom	Never(0)

5. Do you feel pain during sexual intercourse?

Always (0)	Usually	Sometimes	Seldom	Never (4)

6. Are you incontinent of urine (leak urine) with sexual activity?

Always (0)	Usually	Sometimes	Seldom	Never (4)

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

Always (0)	Usually	Sometimes	Seldom	Never(4)

8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling our?)?

Always (0)	Usually	Sometimes	Seldom	Never (4)

9. When you have sex with your partner, do you have negative emotional reactions such as fear, d'sgust, shame or guilt?

Always (0)	Usually	Sometimes	Seldom	Never(4)

10. Does *yo*ur partner have a problem with erections that affects your sexual activity?

Always(0)	Usually	Sometimes	Seldom	Never(4)

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

Always(0)	Usually	Sometimes	Seldom	Never(4)

12. Compared to orgasms *you* have had in the past, how intense are the orgasms you have had in the past six months?

Much less intense (0)	Less intense	Same intensity	More intense	Much more intense (4)

For Clinic Use Only

Scoring

Scores are calculated by totaling the scores for each question with 0-never, 4=always. Reverse scoring is used for items 1,2,3 and 4. The short form questionna're can be used with up to two missing responses. To handle missing values the sum is calculated by multiplying the number of items by the mean of the answered items. If there are more than two missing responses, the short form no longer accurately predicts long form scores. Short form scores can only be reported as total or on an item basis. Although the short form reflects the content of the three factors in the long form, it is not possible to analyze data at the factor level. To compare long and short form scores multiply the short form score by 2.58