SYMPTOM MONITOR

Name: ______________________ Date: ______________________

Occupation: ______________________ Hobbies: ______________________

Complaints 1. ______________________

2. ______________________

When did it start? ______________________

How did it start? ______________________

LOSS OF CONTINENCE ☐ **Yes** ☐ **No (don't fill in chart)**

Please put an **X** next to the statements that best describe your symptoms:

☐ My incontinence is associated with activities such as sneezing, running or coughing ☐ daily ☐ weekly

S

☐ My incontinence is preceded by a strong sensation that feels uncontrollable ☐ daily ☐ weekly

U

☐ My incontinence is associated with frequency of urination during the day (>5-7 X/day) __ # times per day

F

☐ My bladder troubles cause frequent nighttime urination __ # times/night

N

☐ My incontinence is associated with frequent nighttime bedwetting __ # times/week

☐ My incontinence requires me to wear pads __ # pads/day

☐ My bladder troubles include incomplete emptying

R

☐ I have pain when I urinate ☐ yes ☐ no ☐ sometimes

☐ I have to strain when I urinate ☐ yes ☐ no ☐ sometimes

TP

☐ I have leakage during intercourse ☐ yes ☐ no ☐ sometimes

☐ I had problems with urination during my childhood ☐ yes ☐ No

#____cups of coffee/day #____cups of water/day #____cups of tea/day # _____ cups of other fluids/day

Do you have trouble sleeping? ☐ Yes ☐ No If yes, ☐ Trouble falling to sleep? ☐ Trouble Staying Asleep?

HISTORY (women only):

pregnancies: ____ # live births: ____ Wt. heaviest baby: ____ lbs ____ oz Length pushing stage: ______ hours

Forceps? ☐ Yes ☐ No Episiotomies? ☐ Yes ☐ No Tears? ☐ Yes ☐ No

HRT? ☐ Yes ☐ No When? _________ Last pap: ______________ Normal? ☐ Yes ☐ No

Sexually Active? ☐ Yes ☐ No Pain with sex? ☐ Yes ☐ No When? ☐ Penetration ☐ Thrusting?

SURGICAL HISTORY (Male and Female):

Abdominal: ☐ When: ______________________________

Pelvic: ☐ When: ______________________________

BOWEL HISTORY:

Frequency: __ /week

Fecal Incontinence: ☐ Yes ☐ No

Fecal Urgency: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

Stool consistency ☐ Loose ☐ Soft/Formed ☐ Hard ☐ Varies

MEDICAL HISTORY:

Urinary Tract Infections ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No ___ #packs/day

Chronic Cough: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Allergies: ______________________________

Height: ____ ft. __ In. Weight: _______ lbs

BMI: (therapist to calculate) _________

Back Problems: ☐ Yes ☐ No

Neck Problems: ☐ Yes ☐ No

Current Meds: ______________________________

Previous Rx (incl. meds): ______________________________

____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
Initial	0	1	2	3	4	5	6
Discharge	0	1	2	3	4	5	6

On a scale from 1-10, please circle and rate your current pain/discomfort

1 2 3 4 5 6 7 8 9 10

The following questions are reproduced with permission from the International Pelvic Pain Society, www.pelvicpain.org

Please read each of the following statements and circle the number that best represents your symptoms:

0 = no pain 1 = mild pain 2 = mild-moderate pain 3 = moderate4 = moderate-severe 5 = severe symptoms

Pain:						
How would you rate your present pain…………………………………………………	0	1	2	3	4	5
Pain when lifting……………………………………………………………………...	0	1	2	3	4	5
Pain when sitting……………………………………………………………………..	0	1	2	3	4	5
Pain when walking……………………………………………………………………	0	1	2	3	4	5
Pain while doing physical activity………………………………………………..	0	1	2	3	4	5
Deep pain with sexual intercourse or sexual activity………………………………..	0	1	2	3	4	5
Pelvic pain lasting hours or days after sexual activity……………………………..	0	1	2	3	4	5
Pain when bladder when full………………………………………………………..	0	1	2	3	4	5
Pain with urination…………………………………………………………………...	0	1	2	3	4	5
Muscle or joint pain…………………………………………………………………..	0	1	2	3	4	5
Abdominal pain………………………………………………………………………	0	1	2	3	4	5
Backache……………………………………………………………………………...	0	1	2	3	4	5
Pain when wearing tight clothing……………………………………………………..	0	1	2	3	4	5
Pain with bowel movement…………………………………………………………	0	1	2	3	4	5
Pain after bowel movement………………………………………………………..	0	1	2	3	4	5
A falling-out feeling or a feeling of pressure in the pelvis……………………………	0	1	2	3	4	5
Bladder Symptoms:	0	1	2	3	4	5
Loss of urine when coughing, sneezing, lifting or laughing……………………………	0	1	2	3	4	5
Frequency of urination versus the normal of once every 2-3 hours…………………..	0	1	2	3	4	5
Urgency or need to urinate with little warning………………………………………...	0	1	2	3	4	5
Loss of urine due to strong urge………………………………………………………..	0	1	2	3	4	5
Difficulty initiating urine stream…………………………………………………………	0	1	2	3	4	5
Urine stream stops and starts………………………………………………………..	0	1	2	3	4	5
Nighttime urinary frequency…………………………………………………………..	0	1	2	3	4	5
Incomplete emptying of urine……………………………………………………………	0	1	2	3	4	5
Bowel Symptoms:	0	1	2	3	4	5
Constipation (fewer than 3 bowel movements/week)……………………………………	0	1	2	3	4	5
Bowel frequency (more than 3 bowel movements/day)…………………………………	0	1	2	3	4	5
Incomplete emptying of bowel………………………………………………………..	0	1	2	3	4	5
Urgency or need to have a bowel movement with little warning………………………	0	1	2	3	4	5
Abdominal bloating or fullness…………………………………………………………	0	1	2	3	4	5
Lumpy or hard stool consistency………………………………………………………	0	1	2	3	4	5
Needing to strain to achieve bowel movement…………………………………………	0	1	2	3	4	5
Fecal incontinence………………………………………………………………………	0	1	2	3	4	5

Since your symptoms began, how much as your lifestyle been affected?

0 = no effect **1** = mild affect **2** = mild-moderate affect **3** = moderate affect **4** = moderate-severe **5** = substantive change

For Women only:

Effect on Daily Life:

Symptoms or pain limits or interferes with work or school……………………………….	0	1	2	3	4	5
Symptoms or pain limits or interferes with social activities………………………………	0	1	2	3	4	5
Symptoms or pain limits or interferes with exercise routine……………………………..	0	1	2	3	4	5
Symptoms or pain limits or interferes with lifting, cleaning, carrying, shopping, etc….	0	1	2	3	4	5
Symptoms or pain limits or interferes with recreational and/or athletic activities……..	0	1	2	3	4	5
Symptoms or pain limits or interferes with sexual activity……………………………….	0	1	2	3	4	5
Symptoms or pain limits or interferes with sleep………………………………………….	0	1	2	3	4	5
Symptoms or pain cause unexplained mood changes…………………………………..	0	1	2	3	4	5
Pain at ovulation (mid-cycle)………………………………………………………………..	0	1	2	3	4	5
Pain level just before period………………………………………………………………..	0	1	2	3	4	5
Pain (not cramps) with period………………………………………………………………	0	1	2	3	4	5
Cramps with your period…………………………………………………………………….	0	1	2	3	4	5
Pain after period is over……………………………………………………………………..	0	1	2	3	4	5
Burning vaginal pain with penetration of tampon or during sex…………………………	0	1	2	3	4	5
Difficulty achieving orgasm (even when aroused)………………………………………..	0	1	2	3	4	5

For Men only:

Effect on Daily Life:

Symptoms or pain limits or interferes with work or school………………………………	0	1	2	3	4	5
Symptoms or pain limits or interferes with social activities……………………………..	0	1	2	3	4	5
Symptoms or pain limits or interferes with exercise routine…………………………….	0	1	2	3	4	5
Symptoms or pain limits or interferes with lifting, cleaning, carrying, shopping, etc…	0	1	2	3	4	5
Symptoms or pain limits or interferes with recreational and/or athletic activities…….	0	1	2	3	4	5
Symptoms or pain limits or interferes with sexual activity………………………………	0	1	2	3	4	5
Symptoms or pain limits or interferes with sleep…………………………………………	0	1	2	3	4	5
Symptoms or pain cause unexplained mood changes………………………………….	0	1	2	3	4	5
Difficulty getting an erection (even when aroused)………………………………………	0	1	2	3	4	5
Difficulty achieving orgasm (even when aroused)……………………………………….	0	1	2	3	4	5

Male Total: _______ / 220
Women Total: _______ / 245