

Patient Name: \_\_\_\_\_



Women's Pelvic Specialty Care  
of New Mexico, LLC

Date of Birth: \_\_\_\_\_

## PROLAPSE and INCONTINENCE QUESTIONNAIRE

Please answer the following questions about your condition. This will help your doctor in the evaluation of your problems.

1. Have you ever had treatment for urinary tract problems?  Yes  No If Yes, what?  Stones  Kidney disease  Tumors
2. Have you had frequent urinary or bladder infections?  Yes  No
3. Is your urine ever bloody?  Yes  No
4. Is it usually painful or difficult for you to pass urine?  Yes  No
5. Is it necessary for you to change positions (sitting to standing or bend over) in order to empty your bladder?  Yes  No
6. Do you leak urine (even small drops), wet yourself, or wet your undergarments? (CHECK ONE FOR EACH QUESTION)
  - ~ When you cough or sneeze?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ When you bend down or lift something up?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ When you walk quickly, jog, or exercise?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ While you are undressing to use the toilet?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ Do you get such a strong and uncomfortable need to urinate that you leak urine, (even small drops) or wet yourself before reaching the toilet?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ Do you have to rush to the bathroom because you get a sudden strong need to urinate?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
7. Do you find it necessary to wear protection because of leakage of urine?  Yes  No  
If yes - number of pads / protection per day: \_\_\_\_\_ Clothing changes per day? \_\_\_\_\_
8. Do you feel a bulge in your vagina or that something is falling out from your vagina?  Yes  No
9. Do you ever lose control of your bowels (leak stool onto your clothing)?  Yes  No
10. Do you ever need to push with a finger in the vagina or rectum to help stool get out?  Yes  No
11. Do you have a problem with constipation?  Yes  No
12. How much are you bothered by your problems with your bladder/leakage of urine?  
 Not at all     Somewhat     Moderately     Quite a bit
- ~ How much are you bothered by your prolapse (vaginal bulge)?  
 Not at all     Somewhat     Moderately     Quite a bit
13. Are you currently sexually active?  Yes  No    a. If No, are you without a partner?  Yes  No  
b. If you are sexually active:
  - ~ Do you avoid sexual activity because of pain?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ Do your bladder problems (leakage or fear of leakage of urine) affect your sexual function?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time
  - ~ Does your prolapse (feeling a bulge in your vagina or that something is falling out from your vagina) affect your sexual function?  
 None of the time     Rarely     Once in a while     Often     Most of the time     All of the time