

INFORMATION ON TREATMENT FOR PELVIC FLOOR DYSFUNCTION AND BLADDER / BOWEL PROBLEMS

IMPORTANT – READ IMMEDIATELY

Your first appointment will take 45 to 90 minutes so plan your time appropriately. Please arrive at least 15 minutes early to complete necessary paperwork.

Your appointment is scheduled for _____ a.m./p.m. on _____

Enclosed please find:

1. MEDICAL HISTORY AND SCREENING QUESTIONNAIRES
2. KEEPING A RECORD OF YOUR BLADDER FUNCTION
3. DAILY VOIDING LOG.

All these forms must be completed prior to your first appointment.

- Begin the voiding log now (FOR 3 DAYS).
- Be sure to read the directions for KEEPING A RECORD OF YOUR BLADDER FUNCTION carefully so your log is as accurate as possible.
- Incomplete information may delay insurance processing and authorization for subsequent treatment.
- Prior to your first appointment we recommend you check with your insurance company regarding coverage for treatment.

The office evaluation of your condition may include:

- Observation of your vaginal/rectal area.
- Internal vaginal/rectal examination of your pelvic floor muscles.
- Measurement of your pelvic floor muscle function with biofeedback equipment using stick-on sensors or internal sensors inserted rectally or vaginally. These instruments record your muscle activity and help evaluate and treat your pelvic floor muscles.
- Exercise instruction for pelvic floor and other muscle groups as indicated.

Return visits for therapy will be scheduled at regular intervals to measure your progress and modify your exercise program as needed. These appointments are important in order to progress your treatment program.

Please feel free to invite someone to accompany you to your appointments if doing so will make you feel more comfortable.

If you have any questions, please telephone _____ 530-242-1728 _____.

Keeping a Record of Bowel and Bladder Function

The main purpose of a bowel diary is to document how your bowel functions. A diary can give your health care provider an excellent picture of your bowel functions, habits and patterns. At first, the diary is used as an evaluation tool. Later, it will be used to measure your progress on bowel retraining.

Please complete a bowel diary every day for 3 days and bring it with you to your appointment.

Your diary will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

Instructions

Column 1 – Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording.

Column 2 – Type and Amount of Fluid and Food Intake

- Record the type and amount of **fluid** you drank
- Record the type and amount of **food** you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3 – Elimination of Urine and Bowel Movements (BM)

Record the time of day and amount of urine emptied by writing a “U” for urinate.

Record a bowel movement with a “BM”.

Place a “U” or “BM”, in the box at the corresponding time interval each time you empty

Also note the stool consistency using the following Bristol Stool Type Scale:

- | | |
|---|--|
| Type 1 - Separate hard lumps, like nuts
(hard to pass) | Type 5 - Soft blobs with clear-cut edges
passed easily) |
| Type 2 - Sausage-shaped but lumpy | Type 6 - Fluffy pieces with ragged
edges, a mushy stool |
| Type 3 - Like a sausage but with cracks
on its surface | Type 7 - Watery, no solid pieces; entirely
liquid |
| Type 4 - Like a sausage or snake,
smooth and soft | |

Column 4 - Amount of Leakage / Stool Loss

Record the amount of urine loss at the time it occurred.

S- SMALL = drop or two of urine

M- MEDIUM = wet underwear

L- LARGE = wet outerwear or floor

Record the amount of stool loss at the time it occurred.

S = Small stain

P = Pea size

T = 1-2 tablespoons

C = Complete BM lost

Column 5 – Was Urge Present?

Describe the urge sensation you had as:

- 1- MILD = first sensation of need to go
- 2- MODERATE = stronger sensation or need
- 3- STRONG = need to get to toilet, move aside!

Column 6 - Activity with Leakage / Notes

Describe the activity associated with the leakage, i.e., coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

Comments – Special problems and new or changed medications go here. If a pad change was needed, record the number used during the day at the bottom of the page.

Daily Voiding Log Sample

Time of Day	Type & Amount of Food & Fluid Intake	Elimination U = Urinate BM= bowel movement type	Amount of Leakage S /M /L S /P/T/ C	Was Urge Present? 1 /2 /3	Activity With Leakage / Notes
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am	Woke up at 6:45 am	U		3	
7:00 am	Coffee, bagel	BM type 4			
8:00 am			M		Fast walking
9:00 am	Apple	U BM	Pea sized	2	No urge control
10:00 am					
11:00 am		U		1	Key in the door
NOON	Tuna sandwich, milk, pear				
1:00 pm					
2:00 pm		M		2	
3:00 pm	Tea, cookies		S		Running water
4:00 pm					
5:00 pm					
6:00 pm	Chicken, corn pudding, salad, apple juice	M		3	
7:00 pm					
8:00 pm			S	3	
9:00 pm					
10:00 pm	To bed at 10:30	M		3	
11:00 pm					

Comments: Week before period _____ Number of pads: _____

Record of Bowel and Bladder Function

Name _____

Date _____

Time of Day	Type & Amount of Food & Fluid Intake	Elimination U = Urinate BM= bowel movement type	Amount of Leakage S/M/L S/P/T/C	Was Urge Present 1/2/3	Activity With Leakage/ notes
Midnight					
1:00 am					
2:00 am					
3:00 am					
4:00 am					
5:00 am					
6:00 am					
7:00 am					
8:00 am					
9:00 am					
10:00 am					
11:00 am					
Noon					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					
7:00 pm					
8:00 pm					
9:00 pm					
10:00 pm					
11:00 pm					

Comments _____

Number of pads used today _____

BLADDER HEALTH QUIZ

1. Do you urinate more than every two hours in the daytime? Y / N
 2. Do you urinate more than once after going to bed? Y / N
 3. Do you have trouble making it to the toilet on time when you have an urge to go? Y / N
 4. Do you strain to pass urine? Y / N
 5. Do you rush to go to the toilet to empty your bladder? Y / N
 6. Are you unable to stop the flow of urine when on the toilet? Y / N
 7. Do you have an urge to go but when you get to the toilet very little urine comes out. Y / N
 8. Do you lack the feeling that you need to go to the toilet? Y / N
 9. Do you empty your bladder frequently, before you experience the urge to pass urine? Y / N
 10. Do you have the feeling your bladder is still full after urinating? Y / N
 11. Do you experience slow or hesitant urinary stream? Y / N
 12. Do you have difficulty initiating the urine stream? Y / N
 13. Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, key in the door) Y / N
 14. Rate the following statement as it applies to you today.
My bladder is controlling my life. 0= not at all true 10 = completely true
- 0 1 2 3 4 5 6 7 8 9 10

If you answer yes to any of these questions you could benefit from conservative treatment for your bladder. Talk to your health care provider for a referral.

SYMPTOM QUESTIONNAIRE

Name _____ Date _____

1. Describe your main problem _____

2. When did your bowel or bladder problem first begin? ___ months ago or ___ years ago
3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

4. Since that time is it: staying the ___ same ___ getting worse ___ getting better.
Why or how? _____
5. Frequency of urination: awake hours _____ times per day, sleep hours ___ times per night.
6. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ___ minutes, ___ hours, ___ not at all
7. The usual amount of urine passed is: ___ small ___ medium ___ large.
8. Frequency of bowel movements ___ times per day, ___ times per week, or _____.
9. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? ___ minutes, ___ hours, ___ not at all
10. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? _____ glasses per day.
11. Rate a feeling of organ "falling out" or pelvic heaviness/pressure:
___ None present
___ Times per month (specify if related to activity or your period)
___ With standing for ___ minutes or ___ hours
___ With exertion or straining
___ Other _____

Skip to question #16 if no leakage.

- | | |
|---|---|
| 12a. Bladder leakage - number of episodes | 12b. Bowel leakage - number of episodes |
| ___ No leakage | ___ No leakage |
| ___ Times per day | ___ Times per day |
| ___ Times per week | ___ Times per week |
| ___ Times per month | ___ Times per month |
| ___ Only with physical exertion/cough | ___ Only with exertion |

- 13a. On average, how much urine do you leak? 13b. How much stool do you lose?
- | | |
|---|--|
| <input type="checkbox"/> No leakage | <input type="checkbox"/> No leakage |
| <input type="checkbox"/> Just a few drops | <input type="checkbox"/> Stool staining |
| <input type="checkbox"/> Wets underwear | <input type="checkbox"/> Small amount in underwear |
| <input type="checkbox"/> Wets outerwear | <input type="checkbox"/> Complete emptying |
| <input type="checkbox"/> Wets the floor | |

14. What form of protection do you wear? (Please complete only one)

- None
 Minimal protection (Tissue paper/paper towel/pantishields)
 Moderate protection (absorbent product, maxipad)
 Maximum protection (Specialty product/diaper)

Other _____

15. On the average, how many pad changes are required in 24 hours? _____ # of pads.

16. Activities/events that cause your symptoms. Check all that apply

- Strong urge to go
 Walking to the toilet
 Changing positions (example - sit to stand)
 No activity changes the problem
 With cough/sneeze/ laugh /yell
 Vigorous activity or exercise (running, weight lifting, jumping)
 Light activity (walking, light housework)
 Sexual activity
 Other, please list _____

17. How has your lifestyle/quality of life been altered or changed because of this problem?
Please respond to all that apply.

Social activities (exclude physical activities), specify _____

Diet /Fluid intake, specify _____

Physical activity, specify _____

Work, specify _____

Other _____

18. Rate your feelings as to the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____.

HEALTH SCREENING QUESTIONNAIRE

Name _____ Date _____ Age _____

Circle any/all of the specific problems or conditions you now have or have ever had. Explain all yes responses below and include the date problem began.

Medical History

- | | |
|-----------------------------------|-----------------------------------|
| Y/N High blood pressure | Y/N Cancer (type) _____ |
| Y/N Diabetes | Y/N Asthma/Emphysema/COPD |
| Y/N Neurologic/Multiple Sclerosis | Y/N Heart disease |
| Y/N Stroke/Head injury | Y/N Broken bones/Joint problems |
| Y/N Allergies | Y/N Low back pain/Sciatica |
| Y/N Latex sensitivity or allergy | Y/N Sexually transmitted diseases |
| Y/N Smoking habit | Y/N HIV/AIDS |
| Y/N Other please describe _____ | |

Date of last pelvic/prostate exam _____ Date of urinalysis _____

Other tests _____

Surgical History

- | | |
|------------------------------------|---------------------------------------|
| Y/N Surgery for your back/spine | Y/N Surgery for your bladder |
| Y/N Surgery for your brain | Y/N Surgery for your prostate |
| Y/N Surgery for your female organs | Y/N Surgery for your abdominal organs |

Other/describe _____

Ob/Gyn History (females only)

- | | |
|---|---------------------------------|
| Y/N Childbirth vaginal deliveries # _____ | Y/N Vaginal dryness |
| Y/N Episiotomy # _____ | Y/N Painful periods |
| Y/N C-Section # _____ | Y/N Menopause - when? _____ |
| Y/N Difficult childbirth # _____ | Y/N Painful vaginal penetration |
| Y/N Prolapse or organ falling out | Y/N Pelvic pain |

Y/N Other /describe _____

Bladder /Bowel

- | | |
|---|---|
| Y/N Trouble initiating urine stream | Y/N Trouble emptying bladder completely |
| Y/N Childhood bladder problems | Y/N Recurrent bladder infections |
| Y/N Constant dribbling of urine | Y/N Constipation/straining for movement |
| Y/N Blood in urine | Y/N Trouble holding back gas/feces |
| Y/N Urinary hesitancy/slow stream | Y/N Trouble feeling bowel/urge/fullness |
| Y/N Trouble feeling bladder urge/fullness | Y/N Difficulty stopping the urine stream |
| Y/N Dribbling after urination | Y/N Straining or pushing to empty bladder |

Y/N Other/describe _____

Explain all yes responses _____

<u>Medication</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____