Canadian Society for Pelvic Medicine
CSPM SCMP
Société Canadienne de Médecine Pelvienne

PELVIC FLOOR
SYMPTOM ASSESSMENT

PELVIC FLOOR DISTRESS INVENTORY

INSTRUCTIONS: Considering your symptoms over the last 3 months please answer each question by checking the best response. We realize that you may not be having problems in some of these areas but please fill out all questions on the form as completely as possible.

Check one box per question below to help us understand if you experience the symptom, and if yes, how much are you bothered by it.

URINARY DISTRESS INVENTORY UDI-6	No	Yes, it bothers me: Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination?					
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?					
Usually experience urine leakage related to coughing, sneezing, or laughing?					
Usually experience small amounts of urine leakage (that is, drops)?					
Usually experience difficulty emptying your bladder?					
Usually experience pain or discomfort in the lower abdomen or genital region?					

COLORECTAL DISTRESS INVENTORY CRADI-8	No	Yes, it bothers me: Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement?					
Feel you have not completely emptied your bowel at the end of a bowel movement?					
Usually lose stool beyond your control if your stool is well formed?					
Usually lose stool beyond your control if your stool is loose?					
Usually lose gas from the rectum beyond your control?					
Usually have pain when you pass your stool?					
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?					
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?					

Check one box per question below to help us understand if you experience the symptom, and if yes, how much are you bothered by it.

PELVIC ORGAN PROLAPSE DISTRESS INVENTORY POPDI-6

	No	Yes, it bothers me:			
		Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen?					
Usually experience heaviness or dullness in the pelvic area?					
Usually have a bulge or something falling out that you can see or feel in your vaginal area?					
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?					
Usually experience a feeling of incomplete bladder emptying?					
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?					

PELVIC FLOOR IMPACT QUESTIONNAIRE

How do the following symptoms or conditions usually affect each of the three areas below?

		Not at all	Somewhat	Moderately	Quite a bit
1. Ability to do household chores (cooking, laundry housecleaning)?	Bladder or urine				
	Bowel or rectum				
	Vagina				
2. Ability to do physical activities such as walking, swimming, or other exercise?	Bladder or urine				
	Bowel or rectum				
	Vagina				
3. Entertainment activities such as going to a movie or concert?	Bladder or urine				
	Bowel or rectum				
	Vagina				
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	Bladder or urine				
	Bowel or rectum				
	Vagina				
5. Participating in social activities outside your home?	Bladder or urine				
	Bowel or rectum				
	Vagina				
6. Emotional health (nervousness, depression, etc)?	Bladder or urine				
	Bowel or rectum				
	Vagina				
7. Feeling frustrated?	Bladder or urine				
	Bowel or rectum				
	Vagina				

SEXUAL FUNCTION QUESTIONNAIRE

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 doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the question, consider your sexuality over the past 6 months.

PELVIC ORGAN PROLAPSE/URINARY INCONTINENCE SEXUAL FUNCTION PISQ-12	Always	Usually	Sometimes	Seldom	Never
How frequently do you experience sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex etc.					
Do you climax (have an orgasm) when having sexual intercourse with your partner?					
Do you feel sexually excited (turned on) when having sexual activity with your partner?					
How satisfied are you with the variety of sexual activities in your current sex life?					
Do you feel pain during sexual intercourse?					
Are you incontinent of urine (leak urine) with sexual activity?					
Does fear of incontinence (either stool or urine) restrict your sexual activity?					
Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out)?					
When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?					
Does your partner have a problem with erections that affects your sexual activity?					
Does your partner have a problem with premature ejaculation that affects your sexual activity?					

	Much less intense	Less intense	Same intensity	More intense	Much more intense
Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?					

RATE YOUR HEALTH TODAY

Under each question, please check the box that best describes your health <u>today</u>.

EQ-5D-5L

	No problems	Slight problems	Moderate problems	Severe problems	Unable
MOBILITY: Do you experience problems walking about?					
SELF-CARE: Do you experience problems washing or dressing your self?					
USUAL ACTIVITIES: Do you experience problems with work, study, housework, family or leisure activities?					

	No pain	Slight pain	Moderate pain	Severe pain	Extreme pain
PAIN / DISCOMFORT: Do you experience any pain or discomfort?					

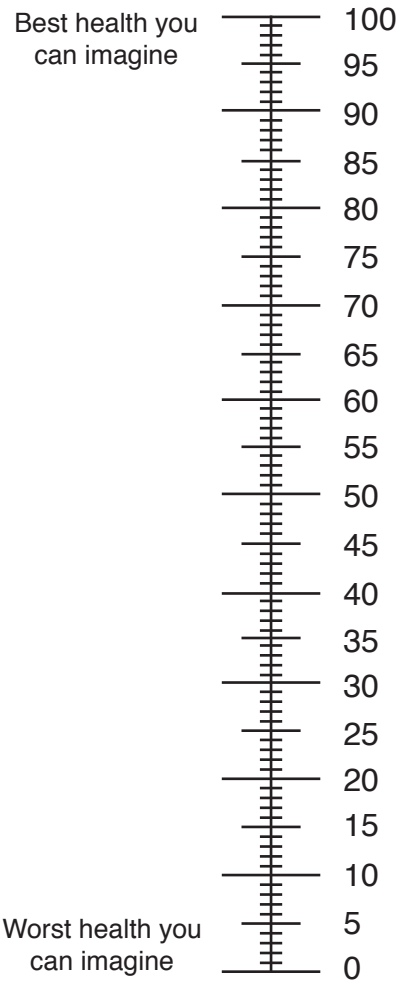
	Not at all	Slightly	Moderately	Severely	Extremely
ANXIETY / DEPRESSION: Are you anxious or depressed?					

Mark an X on the scale to indicate how your health is today.

Then, write the number you marked on the scale in the box below.

- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine
- 0 means the worst health you can imagine

Your health <u>TODAY</u> = ☐



FULL NAME: _____

SIGNATURE: _____

DATE: _____
MM/DD/YYYY