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ST JOHN OF GOD BERWICK

NAME:

DATE:

Post Operative Patient Questionnaire

Pelvic Floor Distress

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms, and if you do, how much they bother you. Answer these questions putting a circle around your answer. 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.

1. **Do you usually experience pressure in the lower abdomen?**

   Y or N

   If Yes, how much does this bother you?

   1. Not at all
   2. Somewhat
   3. Moderately
   4. Quite a bit

2. **Do you usually experience heaviness or dullness in the pelvic area?**

   Y or N

   If Yes, how much does this bother you?

   1. Not at all
   2. Somewhat
   3. Moderately
   4. Quite a bit

3. **Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?**

   Y or N

   If Yes, how much does this bother you?

   1. Not at all
   2. Somewhat
   3. Moderately
   4. Quite a bit

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4. **Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?**

   Y or N

   If Yes, how much does this bother you?

   1. Not at all
   2. Somewhat
   3. Moderately
   4. Quite a bit

5. **Do you usually experience a feeling of incomplete bladder emptying?**

   Y or N

   If Yes, how much does this bother you?

   1. Not at all
   2. Somewhat
   3. Moderately
   4. Quite a bit

6. **Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?**

   Y or N

   If Yes, how much does this bother you?

   1. Not at all
   2. Somewhat
   3. Moderately
   4. Quite a bit

7. **Do you usually experience urine leakage related to coughing, sneezing or laughing?**

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Y or N

If Yes, how much does this bother you?

1. Not at all
2. Somewhat
3. Moderately
4. Quite a bit

8. **Do you usually experience small amounts of urine leakage (that is, drops)?**

Y or N

If Yes, how much does this bother you?

1. Not at all
2. Somewhat
3. Moderately
4. Quite a bit

9. **Do you usually experience difficulty emptying your bladder?**

Y or N

If Yes, how much does this bother you?

1. Not at all
2. Somewhat
3. Moderately
4. Quite a bit

10. **Do you usually experience pain or discomfort in the lower abdomen or genital region?**

Y or N

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If Yes, how much does this bother you?

1. Not at all
2. Somewhat
3. Moderately
4. Quite a bit

11. **Do you usually experience small amounts of urine leakage (that is, drops)?**

Y or N

If Yes, how much does this bother you?

1. Not at all
2. Somewhat
3. Moderately
4. Quite a bit

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Pelvic Organ Prolapse/Urinary Incontinence Sexual Function

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 circle the answer that best answers the question for you. While answering the questions, consider your sexuality over the past SIX MONTHS.

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**

1. Daily
2. Weekly
3. Monthly
4. Less than once a month
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

5. **Do you feel pain during sexual intercourse?**

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1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually

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3. Sometimes
4. Seldom
5. Never

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

1. Always
2. Usually
3. Sometimes
4. Seldom
5. Never

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

1. Much less intense
2. Less intense
3. Same intensity
4. More intense
5. Much more intense

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Health Questionnaire

Please indicate which statement best describes your own health state TODAY by placing a tick next to the most appropriate answer.

- **MOBILITY**

I have no problems in walking about

I have some problems in walking about

I am confined to bed

- **SELF-CARE**

I have no problems with self-care

I have some problems washing and dressing myself

I am unable to wash or dress myself

- **USUAL ACTIVITIES (work, study, housework, family or leisure activities)**

I have no problems with performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

- **PAIN/DISCOMFORT**

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

- **ANXIETY/DEPRESSION**

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is TODAY, in your opinion.

Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is TODAY.

Your Own
Health State
Today