

Saskatchewan Pelvic Floor Pathway

Addressograph

Instructions to patient: 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 both sides of this form as completely as possible.**

PELVIC FLOOR DISTRESS INVENTORY

Urinary Distress Inventory (UDI-6):

If YES, check one box.

Do you experience, and <u>if yes</u> how much are you bothered by:	Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience urine leakage related to coughing, sneezing, or laughing? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience small amounts of urine leakage (that is, drops)? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience difficulty emptying your bladder? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience pain or discomfort in the lower abdomen or genital region? <input type="checkbox"/> No <input type="checkbox"/> Yes				

Colorectal Distress Inventory (CRADI-8)

If YES, check one box.

Do you experience, and <u>if yes</u> how much are you bothered by:	Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Feel you have not completely emptied your bowel at the end of a bowel movement? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually lose stool beyond your control if your stool is well formed? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually lose stool beyond your control if your stool is loose? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually lose gas from the rectum beyond your control? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you usually have pain when you pass your stool? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? <input type="checkbox"/> No <input type="checkbox"/> Yes				

<i>Pelvic Organ Prolapse Distress Inventory (POPDI-6)</i>	<i>If YES, check one box.</i>			
Do you experience, and <u>if yes</u> how much are you bothered by:	Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience heaviness or dullness in the pelvic area? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually have a bulge or something falling out that you can see or feel in your vaginal area? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Usually experience a feeling of incomplete bladder emptying? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination? <input type="checkbox"/> No <input type="checkbox"/> Yes				

PELVIC FLOOR IMPACT QUESTIONNAIRE

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

Name: _____ Date: _____ Signature: _____