



Pelvic Floor Dysfunction Inventory

Please answer ALL questions as best you can.

Do you experience:

	No, does not occur	Yes, does not bother me	Yes, bothers me slightly	Yes, bothers me moderately	Yes, bothers me greatly
1. Pressure in the lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Heaviness or dullness in the pelvic area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Bulging or something falling out of that you can see or feel in your vaginal area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever have to push on the vagina or around the rectum to complete a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever have to push up on a bulge in the vaginal area with your fingers to complete urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you feel as if you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Lose stool beyond your control if your stool is well formed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Lose stool beyond your control if your stool is loose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Lose gas from the rectum beyond your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have pain when you pass your stool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Urine leakage related to the feeling of urgency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Urine leakage related to physical activity, coughing, or sneezing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Small amounts of urine leakage (that is drops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Pain or discomfort in the lower abdominal or genital area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Wichita Women's Pelvic Surgery Center

At Associates In Women's Health, P.A.

Pelvic Floor Impact Questionnaire

Please answer ALL questions as best you can.

How do symptoms or conditions relate to the following:	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
1. Ability to do household chores (cooking, cleaning, laundry, 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
2. Physical recreational 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 longer than 30 minutes 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. Does your problem cause you to experience frustration?	<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

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Following is 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 us understand what is important to you about your sex life. Please mark the answers that best answers your sexuality over the past six months.

Please answer ALL questions as best you can.

Do you experience:

	Always	Usually	Sometimes	Seldom	Never
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with the variety of sexual activities in your current sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel pain during sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you incontinent (leak urine) with sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your partner have a problem with erections that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Much Less Intense	Less Intense	Same Intensity	More Intense	Much More Intense
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>