Patient questionnaire anamnesis

Patient stickers

Dear patient,

To provide you with the best possible treatment and care, we would like to ask you a few questions beforehand. Your answers will help us select the best possible therapy approach for you.

Your information is, of course, entirely voluntary.

This medical history form is part of your medical file and will be treated with the same confidentiality.

Please answer all questions carefully, as this information will help us provide you with the best possible support. Often, your first thought is the right one. There are no wrong answers. If you are unable to answer a question, simply move on to the next one. If anything is unclear, please contact us.

If you do not wish to answer any questions, please leave them unanswered.

Thank you for your cooperation!

Your pelvic floor team

A General Information

Please provide the following information:	
Her age	_____ Years
Your size	_____ cm
Your weight	_____ kg

A1	No	Yes
Have you given birth to children?	☐	☐
If yes, how many children?	_____ number of child(ren)	
How many were delivered by cesarean section:	_____ number of cesarean sections	

A2	No	Yes
Was at least one child particularly heavy or tall? (Weight over 4000 g)?	☐	☐

A3 Do you still have your **menstruation**?

☐	Yes, regularly, last on: _____
☐	Yes, irregularly, last on: _____
☐	No, not since the _____ year of age.
☐	No, not since the hysterectomy in _____.

A4	No	Yes
Do you currently have menopausal symptoms (e.g., hot flashes, sleep disturbances, Mood swings, joint pain, etc.)?	☐	☐

A5 How much fluid do you usually drink per day on average?

I drink an average of _____ liters a day.

A6	No	Yes
Do you **smoke**?	☐	☐
If yes, how many cigarettes a day?		
Less than 15 cigarettes per day ☐	More than 15 cigarettes per day ☐	

A7	Do you have any pre-existing medical conditions (e.g., diabetes, heart failure, high blood pressure) or **Diseases of the nervous system**(e.g., multiple sclerosis, herniated disc)?
No	☐
Yes	☐ ➔ **What pre-existing conditions?:**

A8	No	Yes
Do you take medication regularly?	☐	☐
If yes, what medications do you take regularly?		

Blood thinning medication	☐	Blood pressure medication	☐
Antidiabetic drugs	☐	Painkillers	☐
Thyroid hormones	☐	Psychotropic drugs	☐
Diuretics (water pills)	☐	Others, namely:	☐

A9 Are you taking hormones?			
No	☐	Yes, as a tablet or injection.	☐
Yes, as a patch or gel	☐	Yes, as a vaginal cream or vaginal suppository.	☐
Yes, something else	☐	Name of the preparation:	

A10 **How often** do you experience …	Daily/Regularly	Frequently	Rarely	Never
…Burning when urinating?	☐	☐	☐	☐
Burning sensation after urination?	☐	☐	☐	☐
…Pain in the bladder area?	☐	☐	☐	☐
…bloody urine?	☐	☐	☐	☐

A11 **How often** do you have…	Regularly	Frequently	Rarely	Never
…a bladder/urinary tract infection?	☐	☐	☐	☐
…Kidney inflammation?	☐	☐	☐	☐
…a disease of the urinary tract (e.g., stones, malformations, tumors)?	☐	☐	☐	☐

B bladder function

B1	No	Yes
Do you have problems with your bladder, such as frequent urination or involuntary urine loss?	☐	☐

➔ If you have no bladder problems, please complete question C1 (bowel function). **further**

B2 How often do you normally need to urinate per day?

Up to 5 times a day	Between 5 and 10 times a day	More than 11 times a day
☐	☐	☐

B3 How **often** do you usually need to go to the toilet at night?

Not at all	1 to 2 times	3 times or more
☐	☐	☐

B4 How strong is your urine stream normally?		
Weak	Medium	Strong
☐	☐	☐

B5	No	Yes	I don't know
Can you voluntarily interrupt or stop your urine stream?	☐	☐	☐

B6 How often do you experience the **feeling** that the bladder is empty after urinating?				
Always	Often / frequently	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

B7 Do you **often** have to … during urination?	No	Yes	I don't know
...have to sit for a long time?	☐	☐	☐
…have to help with their finger?	☐	☐	☐
…have to press hard?	☐	☐	☐

B8 **How** quickly do you need to find a toilet when the urge to urinate starts normally?			
I need to go to the toilet immediately and I usually lose urine on the way	I need to go to the toilet immediately but without losing urine on the way	Within the next 15 minutes	I can wait.
☐	☐	☐	☐

B9 Do you often experience a sudden urge to urinate that cannot be suppressed or held back?			
Daily	Once a week or several times a week	Rarely	Never
☐	☐	☐	☐

B10 Does it ever happen that you **unintentionally lose** urine?			
Yes, several times a day	Yes, once or twice a day	Yes, rarely (not daily)	Never
☐	☐	☐	☐

➔ **If you never involuntarily lose urine**, then please continue with question B16

B11 How **large** are the amounts of urine you involuntarily lose?

Large quantities	Medium-sized quantities / splashes	A few drops / small amounts
☐	☐	☐

B12 **When** do you experience involuntary urine loss?

When coughing, sneezing, laughing	☐	During heavier loads such as lifting, jumping	☐
For lighter activities such as walking, running, climbing stairs	☐	When changing from lying down to standing / When changing from standing to lying down	☐
While lying down / while sleeping	☐	Standing (without weight-bearing)	☐
In case of excitement	☐	During sexual activities	☐
Without any apparent cause	☐	In other situations, namely:	☐

B13 Do you use pads or liners due to involuntary urine loss?

No	Yes, but only when I leave the house.	Yes, always
☐	☐	☐

➔ **If you are not wearing pads or liners**, then please continue with question B 15

B14 How **often** do you usually have to change your sanitary pads, liners, or underwear?

I don't even need to change them.	I have to do it once or twice a day. change	I have to change them several times a day.
☐	☐	☐

B15 **How** often do you restrict your fluid intake to avoid urinary incontinence?

Not at all	☐	Only if I'm away for an extended period of time	☐
Only, before going to sleep	☐	Even if I'm only gone for a short time	☐
Always, regardless of what I'm planning.	☐	Only in other situations, namely:	☐

B16 Which oft he both statements do you agree with regarding your bladder function?			
My bladder functions without any problems.	☐	I'm having problems with my bladder function.	☐

➔ **If your bladder functions without problems**, then please continue with question C 1 (bowel function)

B17 How much is your bladder problem bothering you?				
So bad that I hardly ever leave the house anymore.	(Very) much	Quite a lot	A little	Not at all
☐	☐	☐	☐	☐

C Bowel function

C1	No	Yes
Do you experience difficulties with bowel movements or uncontrolled stool loss?	☐	☐

➔ If you have no problems with bowel movements, then please complete question D1. **(Pelvic organ prolapse symptoms)further**

C2 What difficulties often occur?	Daily/Regularly	Frequently	Rarely	Never
constipation	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Pain during bowel movements	☐	☐	☐	☐
Gas or wind escapes accidentally, without me being able to hold it back.	☐	☐	☐	☐
I can't empty my bowels properly.	☐	☐	☐	☐
I need assistance with bowel movements.	☐	☐	☐	☐
Uncontrolled stool loss	☐	☐	☐	☐
I have to strain very hard during bowel movements.	☐	☐	☐	☐
Sudden urge to defecate that I cannot suppress	☐	☐	☐	☐

C3 Which of both statements do you agree with regarding your bowel function?			
My bowel functions without problems	☐	I have problems with the function of my intestines.	☐

➔ **If your bowel is functioning without problems**, then please continue with question D 1

C4 How **much** is your bowel problem bothering you?

So bad that I hardly ever leave the house anymore.	(Very) much	Quite a lot	A little	Not at all
☐	☐	☐	☐	☐

D Reduction

D1 Do you have **Prolapse symptoms** such as pressure or a feeling of a foreign body in the vaginal area? (Multiple selections possible)

No	☐	Yes, a feeling of pressure in the vaginal area.	☐
Yes, a foreign body sensation in the vaginal area	☐	Yes, sometimes something bulges up to the vaginal opening.	☐

D2 **Which** of both statements do you agree with regarding possible symptoms of prolapse (such as pressure or foreign body sensations in the vaginal area)?

I have no symptoms of prolapse.	☐	I have symptoms of prolapse.	☐

➔ **If you have no symptoms of prolapse**, then please continue with question E 1 (sexuality).

D3 How **much** is your prolapse symptoms bothering you?

(Ver) much	Quite a lot	A little	Not at all
☐	☐	☐	☐

E sexuality

E1 Are you sexually active?

No, I am not active.	Yes, rarely	Yes, regularly
☐	☐	☐

E2	No	Yes	I am not sexually
Do you ever experience difficulties or problems with intercourse or sexual activities?	☐	☐	☐

E3 If so, what **Problems** occur regularly during sexual activity? (Multiple answers possible)

Urinary incontinence	☐	Pain	☐
vaginal dryness	☐	Feeling of tightness / excessive firmness	☐
Feeling of flaccidity / excessive spaciousness	☐	Other, namely:	☐

E4 How **much** do your problems interfere with sexual activity?

(Very) much	Quite a lot	A little	Not at all
☐	☐	☐	☐

E5	No	Yes
If you are currently not sexually active, can you imagine becoming active again in the future?	☐	☐

F Previous treatment and assessment

F1

How long, or for how many years, have you had these symptoms?	_____ Years

F2 How were your **complaints** previously covered?

Not at all	☐	Medications	☐
Physiotherapy / Pelvic floor exercises	☐	Electrical stimulation / bio-feedback	☐
Pessary (cube, ring)	☐	surgery	☐
Bladder conditioning training	☐	Other things, namely:	☐

F3 **Who** has been involved or included in the treatment so far?			
Family doctor	☐	Specialist (e.g., gynecologist, urologist)	☐
Hospital doctor	☐	Other, namely:	☐

F4 How **satisfied** are you with the success of the treatment so far?			
Very satisfied	Satisfied	Unsatisfied	Very dissatisfied
☐	☐	☐	☐

F5 Have you ever had surgery on your lower abdomen?			
No	☐	Yes, hysterectomy through the vagina	☐
Yes, hysterectomy via abdominal incision	☐	Yes, prolapse surgery through the vagina	☐
Yes, bladder lift via an abdominal incision	☐	Yes, insertion of a plastic band to correct involuntary urine loss.	☐
Yes, insertion of a plastic mesh to correct a vaginal prolapse	☐	Other:	☐

F6 To what extent do the complaints/symptoms affect your daily life (e.g., sports, shopping, etc.) Go out)?					
So bad that I hardly ever leave the house anymore.	(Very strong	Quite	A little	Not at all	I have no symptoms/complaints
☐	☐	☐	☐	☐	☐

F7 If your daily life is affected by your symptoms, in which areas do you experience a significant limitation in your daily life? (Multiple answers possible).			
Shopping	☐	homework	☐
Meeting up with friends/ Going out	☐	sport	☐
emotional state	☐	Sleep / Energy	☐
Work / Profession	☐	Travel	☐
Sexual intercourse / sexual activities	☐	Other, namely:	☐

Thank you for your support!