

VULVAR PAIN FUNCTIONAL QUESTIONNAIRE (V-Q)

These are statements about how your pelvic pain affects your everyday life. Please check one box for each item below, choosing the one that best describes your situation. Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment. Your responses will be kept completely confidential at all times.

1. Because of my pelvic pain
 - 3 I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.
 - 2 I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.
 - 1 I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.
 - 0 I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain
 - 3 Gets worse when I walk, so I can only walk far enough to move around in my house, no further.
 - 2 Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
 - 1 Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
 - 0 My pain does not get worse with walking; I can walk as far as I want to
 - 0 I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain
 - 3 Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
 - 2 Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
 - 1 Occasionally gets worse when I sit, but most of the time sitting is comfortable.
 - 0 My pain does not get worse with sitting, I can sit as long as I want to.
 - 0 I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills I take for my pelvic pain
 - 3 I am sleepy and I have trouble concentrating at work or while I do housework.
 - 2 I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
 - 1 I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
 - 0 I don't have any problems with the pills that I take for pelvic pain.
 - 0 I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain
 - 3 I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
 - 2 It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
 - 1 Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
 - 0 It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
- 3 I don't get together with my friends or go out to parties or events.
 - 2 I only get together with my friends or go out to parties or events every now and then.
 - 1 I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
 - 0 I get together with friends or go to events whenever I want, pelvic pain does not get in the way
7. Because of my pelvic pain
- 3 I can't stand for the doctor to insert the speculum when I go to the gynecologist.
 - 2 I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
 - 1 It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
 - 0 It never hurts for the doctor to insert the speculum when I go to the gynecologist.
8. Because of my pelvic pain
- 3 I cannot use tampons at all, because they make my pain much worse.
 - 2 I can only use tampons if I put them in very carefully.
 - 1 It usually doesn't hurt to use tampons, but occasionally it does hurt.
 - 0 It never hurts to use tampons.
 - 0 This question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.
9. Because of my pelvic pain
- 3 I can't let my partner put a finger or penis in my vagina during sex at all.
 - 2 My partner can put a finger or penis in my vagina very carefully, but it still hurts.
 - 1 It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.
 - 0 It doesn't hurt to have my partner put a finger or penis in my vagina at all.
 - 0 This question does not apply to me because I don't have a sexual partner.
 - 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.
10. Because of my pelvic pain
- 3 It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.
 - 2 My partner can touch me sexually outside the vagina if we are very careful
 - 1 It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt
 - 0 It never hurts for my partner to touch me sexually outside the vagina
 - 0 This question does not apply to me because I don't have a sexual partner.
 - 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.
11. Because of my pelvic pain
- 3 It is too painful to touch myself for sexual pleasure.
 - 2 I can touch myself for sexual pleasure if I am very careful.
 - 1 It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.
 - 0 It never hurts to touch myself for sexual pleasure.
 - 0 I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.

KEEPING A RECORD OF BLADDER FUNCTION

Please complete a bladder log every day for 2 days and bring it to the course. Please do at least one day of specific urine output measurement (Method # 3) and one on working day.

The main purpose of a bladder log is to document how your bladder functions. A log can give your health care provider an excellent picture of your bladder functions, habits and patterns. At first, the log is used as an evaluation tool. Later, it will be used to measure your progress on bladder retraining or leakage episodes.

Your log will be more accurate if you fill it out as you go through the day. It can be very difficult to remember at the end of the day exactly what happened in the morning.

INSTRUCTIONS

Column 1 - Time of Day

The log begins with midnight and covers a 24 hour period. Afternoon times are in bold. Select the hour block that corresponds with the time of day you are recording information.

Column 2 - Type & Amount of Fluid & Food Intake

- Record the type and amount of fluid you drank
- Record the type and amount of food you ate
- Record when you woke up for the day and the hour you went to sleep

Column 3 - Amount Voided (Urinated): Three methods

Record the time of day and amount voided. Use the first method unless directed by your health care provider to directly measure or count urine amounts. Record a bowel movement with a BM at the appropriate time.

1. Place an S,M,L, in the box at the corresponding time interval each time you urinate.
S- SMALL= seemed like a small amount, or urinated "just in case".
M- MEDIUM= seemed like an 8 ounce measuring cup would run over.
L- LARGE= seemed like the amount you urinate when you first wake up in the morning.
- ② If you have difficulty gauging the amount of urine, you may record seconds by counting "one - one thousand" (this equals one second) while emptying your bladder. Record the total number of seconds it took you to void.
- ③ Measure urine amounts with a collection device. The best method is a collection "hat" that can be placed directly over the toilet. Some people use 2-4 cup measuring containers, but it is sometimes difficult to catch the urine with these. Record the measured ounces of urine in the box at the corresponding time interval each time you urinate.

Column 4 - Amount of Leakage

Record the amount of urine loss at the time it occurred.

- S- SMALL= drop or two of urine
- M- MEDIUM= wet underwear
- L- LARGE= wet outerwear or floor

Column 5 - Was Urge Present

Describe the urge sensation you had as:

- 1- MILD= first sensation of need to go
- 2- MODERATE= stronger sensation or need
- 3- STRONG= need to get to toilet, move aside!

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Column 6 - Activity with Leakage

Describe the activity associated with the leakage, i.e. coughed, heard running water, sneezed, bent over, lifted something or had a strong urge.

Comments – (at the bottom of the log table) Special problems and new or changes in medication are recorded here. If a pad change was needed, record the number used during the day at the bottom of the page.

Daily Voiding Log Sample

| Time of Day | Type & Amount of Food & Fluid Intake | Amount Voided in (Ounces) or (S / M / L) or (Seconds) | Amount of Leakage S / M / L | Was Urge Present 1 / 2 / 3 | Activity With Leakage |
|-------------|-------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------|-------------------------------|-----------------------|
| Midnight | | | | | |
| 1:00 am | | | | | |
| 2:00 am | | | | | |
| 3:00 am | | | | | |
| 4:00 am | | | | | |
| 5:00 am | | | | | |
| 6:00 am | Woke up at 6:45 am | L | | 3 | |
| 7:00 am | Coffee, bagel | | | | |
| 8:00 am | | | M | | Fast walking |
| 9:00 am | Apple | M | | 2 | |
| 10:00 am | | | | | |
| 11:00 am | | S | | 1 | Key in the door |
| NOON | Tuna sandwich, milk, pear | | | | |
| 1:00 pm | | | | | |
| 2:00 pm | | M | | 2 | |
| 3:00 pm | Tea, cookies | | S | | Running water |
| 4:00 pm | | | | | |
| 5:00 pm | | | | | |
| 6:00 pm | Chicken, corn pudding, salad, apple juice | M | | 3 | |
| 7:00 pm | | | | | |
| 8:00 pm | | | S | 3 | |
| 9:00 pm | | | | | |
| 10:00 pm | To bed at 10:30 | M | | 3 | |
| 11:00 pm | | | | | |

Comments: week before period Number of pads: 2

DAILY VOIDING LOG

Name _____

Date _____

| Time of Day | Type & Amount of Food & Fluid Intake | Amount Voided Ounces, S / M / L or Seconds | Amount of Leakage S / M / L | Was Urge Present 1 / 2 / 3 | Activity With Leakage |
|-------------|--------------------------------------|--------------------------------------------|-----------------------------|----------------------------|-----------------------|
| Midnight | | | | | |
| 1:00 am | | | | | |
| 2:00 am | | | | | |
| 3:00 am | | | | | |
| 4:00 am | | | | | |
| 5:00 am | | | | | |
| 6:00 am | | | | | |
| 7:00 am | | | | | |
| 8:00 am | | | | | |
| 9:00 am | | | | | |
| 10:00 am | | | | | |
| 11:00 am | | | | | |
| Noon | | | | | |
| 1:00 pm | | | | | |
| 2:00 pm | | | | | |
| 3:00 pm | | | | | |
| 4:00 pm | | | | | |
| 5:00 pm | | | | | |
| 6:00 pm | | | | | |
| 7:00 pm | | | | | |
| 8:00 pm | | | | | |
| 9:00 pm | | | | | |
| 10:00 pm | | | | | |
| 11:00 pm | | | | | |

Comments _____

Number of pads used today _____

PELVIC FLOOR QUESTIONNAIRE

Name _____ Physician _____ Date _____

Please describe your main problem _____

When did it begin? _____ Is it getting: better, worse, or staying the same (circle one)

Please describe activities or things that you cannot do because of your problem.

Please list all pelvic and abdominal surgeries with dates of operation.

Date of last pelvic examination _____ Date of last urinalysis _____

Special Tests Performed? _____ Type _____ Date _____

1. OCCURRENCE OF INCONTINENCE OR LEAKAGE

- Never
- Less than 1/month
- More than 1/month
- Less than 1/week
- More than 1/week
- Almost every day
- # ___ leaks per day

2. PROTECTION USED

- No Protection
- Pantishields
- Mini Pad
- Maxi Pad
- Bladder control pad type _____
- Diaper

3. SEVERITY

- No leakage
- Few drops
- Wet underwear
- Wet outerwear

4. POSITION OR ACTIVITY WITH LEAKAGE

- Lying down
- Sitting
- Standing
- Changing positions (sit to stand)
- Sexual activity
- Strong Urge

5. HOW LONG CAN YOU DELAY THE NEED TO URINATE?

- Indefinitely
- 1+ hours
- ½ hour
- 15 minutes
- Less than 10 minutes
- 1-2 minutes
- Not at all

6. ACTIVITY THAT CAUSES URINE LOSS

- Vigorous activity
- Moderate activity
- Light activity
- No activity
- Type _____

7. PROLAPSE (Falling Out Feeling)

- Never
- Occasionally/with menses
- Pressure at the end of the day
- Pressure with straining
- Pressure with standing
- Perineal pressure all day

8. FREQUENCY OF URINATION (DAYTIME)
- 0 times per day
 - 1-4
 - 5-8
 - 9-12
 - 13+
9. FREQUENCY OF URINATION (NIGHTTIME)
- 0 times per night
 - 1
 - 2
 - 3
 - 4+
10. FLUID INTAKE
- Includes water and beverages
 - 9+ 8oz glasses per day
 - 6-8 8oz glasses per day
 - 3-5 8 oz glasses per day
 - 1-2 8 oz glasses per day
 - How many caffeinated glasses? _____
11. FREQUENCY OF BOWEL MOVEMENTS
- 2 times per day
 - 1 time per day
 - Every other day
 - Once every 4-7 day
 - Weekly
12. AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?
- Can stop completely
 - Can maintain a deflection of the stream
 - Can partially deflect the urine stream
 - Unable to deflect or slow the stream
13. DO YOU HAVE TROUBLE INITIATING A URINE STREAM?
- Never
 - More than 1/month
 - Less than 1/week
 - Almost every day
14. ATTITUDE TOWARDS PROBLEM
- No problem
 - Minor inconvenience
 - Slight problem
 - Moderate problem
 - Major problem
15. CONFIDENCE IN CONTROLLING YOUR PROBLEM
- Complete confidence
 - Moderate confidence
 - Little confidence
 - No confidence
16. Are you sexually active? Yes _____ No _____
 Are you pregnant or attempting pregnancy? Yes _____ No _____
 Number of pregnancies? _____ Complications? _____
17. History of or present sexually transmitted diseases? Type _____
18. Do you have pain or problems with sexual activity or urination?
 Describe _____
19. Have you ever been taught how to do pelvic floor/Kegel exercises?
 Yes ___ No ___ When? _____ By whom? _____
20. How often do you do pelvic floor exercises? _____
- Any comments or concerns not asked?

QUALITY OF LIFE & SYMPTOMS DISTRESS INVENTORY

NAME _____ DATE _____

Please answer each question by checking the best response between 0 (not at all) and 3 (greatly).

Incontinence impact questionnaire

| Has urinary leakage and/or prolapse affected your: | 0= not at all | 1= slightly | 2= moderately | 3= greatly | |
|----------------------------------------------------------------------|------------------|----------------|------------------|---------------|----|
| 1. Ability to do household chores (cooking, housecleaning, laundry)? | | | | | PA |
| 2. Physical recreation such as walking, swimming, or other exercise? | | | | | PA |
| 3. Entertainment activities (movies, concerts, etc.)? | | | | | T |
| 4. Ability to travel by car or bus more than 30 minutes from home? | | | | | T |
| 5. Participation in social activities outside your home? | | | | | SR |
| 6. Emotional health (nervousness, depression, etc.)? | | | | | EH |
| 7. Feeling frustrated? | | | | | EH |

Urogenital distress inventory

| Do you experience, and, if so, how much are you bothered by: | 0= not at all | 1= slightly | 2= moderately | 3= greatly | |
|-----------------------------------------------------------------------|------------------|----------------|------------------|---------------|----|
| 1. Frequent urination? | | | | | I |
| 2. Urine leakage related to the feeling of urgency? | | | | | I |
| 3. Urine leakage related to physical activity, coughing, or sneezing? | | | | | S |
| 4. Small amounts of urine leakage (drops)? | | | | | S |
| 5. Difficulty emptying your bladder? | | | | | OD |
| 6. Pain or discomfort in the lower abdominal or genital area? | | | | | OD |
| 7. A feeling of bulging or protrusion in the vaginal area? | | | | | OU |
| 8. Bulging or protrusion you can see in the vaginal area? | | | | | OD |

PA=physical activity; T=travel; SR=social/relationships; EH=emotional health;
OD=obstructive/discomfort symptoms; I=irritative symptoms; S=stress symptoms.