tanvir hospital
an extended home
Plot no.100
Kam alapuri Colony
Hyderabad- 500 073
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Tanvir Hospital

DATE TODAY

In Tanvir Hospital, we strive to provide the best care possible to our patients. In order to understand your problem/problems better and thus finding the best solution, we would like you to fill out the following questionnaire to the best of your knowledge before your clinic appointment.

Please answer all questions even if some of them may seem irrelevant to you as new problem/problems can arise after any form of treatment. This questionnaire can also be used as a tool for quality assurance for your care. Thank you!

NAME:

DATE OF BIRTH:

ADDRESS & Phone number :

Height : Weight : Does your daily work involve heavy lifting ? Yes/ No

A1. Describe the kind of problem you have.

A2. How long have you had the problem? Please state in months/years.

A3. Has the problem become worse, better or changed at all?

When answering the questions, think about the symptoms you have experienced in the past month. Please only circle one appropriate answer per question.

URINARY SYMPTOMS (modified King's Health Questionnaire)

We would like to know what your bladder problems are and how much they affect you? Are you affected by following urinary problems?

B1. FREQUENCY(going to the toilet very often) YES / NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

B2. NOCTURIA (getting up at night to pass urine) YES / NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B3. URGENCY (a strong and difficult to control desire to pass urine) YES / NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B4. URGE INCONTINENCE (urinary leakage associated with a strong desire to pass urine) YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B5. STRESS INCONTINENCE (urinary leakage with physical activity eg. coughing, running) YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B6. NOCTURNAL ENURESIS (wetting the bed at night) YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B7. WATER WORKS INFECTIONS YES / NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B8. BLADDER PAIN YES / NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

B9. Do you do any of the following? If so how much?

- Wear pads to keep dry?

  ○ not at all ○ a little ○moderately ○ a lot
- Be careful how much fluid you drink?

  ○ not at all ○ a little ○moderately ○ a lot
- Change your underclothes because they get wet?

  ○ not at all ○ a little ○moderately ○ a lot
- Worry in case you smell?

  ○ not at all ○ a little ○moderately ○ a lot

Past Urinary Symptoms

Have you ever had any of the following?

B10. Bedwetting over the age of 7 years YES / NO

B11. Blood in the urine. YES / NO

Treatment for bladder problems.

Please give details if and when you have had any of the following

Test or investigations _____

Physiotherapy / pelvic floor exercises. _____

Medicines. Eg. Tablets, vaginal creams. _____

Did any of these things help? _____

PROLAPSE SYMPTOMS (POPDI-6)

C1. Do you usually experience pressure in the lower abdomen? YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○○moderately ○ a lot

C2. Do you usually experience heaviness or dullness in the pelvic area? YES /NO

If yes, how much does this bother you?

○ not at all ○a little ○○moderately ○○ a lot

C3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? YES /NO

If yes, how much does this bother you?

○not at all ○a little ○ ○moderately ○a lot

C4. Do you usually have to push on the vagina or around the rectum to have or complete a bowle movement ? YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

C5. Do you usually experience a feeling of incomplete bladder emptying? YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

C6. Do you ever have to push on a bulge in the vaginal area with your fingers to start or complete urination? YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○moderately ○ a lot

BOWEL HABITS (CRADI-8)

D1. Do you feel you need to strain too hard to have a bowel movement? YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

D2. Do you feel you have not completely emptied your bowel at the end of a bowel movement? YES /NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

D3. Do you usually lose stool beyond your control if your stool is well formed? YES /NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

D4. Do you usually lose stool beyond your control if your stool is loose or liquid? YES /NO

If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

D5. Do you usually lose gas from the rectum beyond your control? YES /NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

D6. Do you usually have pain when you pass your stool? YES /NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

D7. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement ? YES /NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

D8. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? YES /NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

SEXUAL MATTERS(modified Bristol lower urinary tract questions (CONT)
(please think about the past month)

Are you sexually active at present? YES/NO
If YES, please go to questionE1.
If NO, please go to question F1.

E1. To what extent do you feel that your sex life has been spoils by your urinary / prolapse Symptoms (means lump sensation in the vagina)?
○ not at all ○ a little ○ moderately ○ a lot
How much of a problem is this for you?
○ Not a problem ○ a bit of a problem ○ quite a problem ○ a serious problem

E2. Do you have pain when you have sexual intercourse? YES/NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lo

E3. Do you leak urine when you have intercourse? YES/NO
If you do, does it occur at…
○ Penetration ○ Orgasm ○ both occasions
○ not at all ○ a little ○ moderately ○ a lot

E4. Do you feel vaginal looseness during intercourse? YES/NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

E5. Do you suffer from vaginal flatus during intercourse? YES/NO
If yes, how much does this bother you?
○ not at all ○ a little ○ moderately ○ a lot

LIFESTYLE IMPACT(please think about the past month)

Below are some daily activities that can be affected by bladder problems.
How much does your bladder problem affect you?

F1. How would you describe your health at the present?

○ very good ○ good ○ fair ○ poor ○ very poor

F2. How much do you think your bladder problem/prolapse affects your life?

○ not at all ○ a little ○ moderately ○ a lot

Role Limitations

F3. Does your bladder problem / prolapse affect your house hold tasks? YES/NO
(cleaning, shopping etc)

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F4. Does your bladder problem / prolapse affect your job, or your normal daily activities outside the home? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

Physical / Social Limitations

F5. Does your bladder problem / prolapse affect your physical activities YES/NO
(e.g. going for a walk, running, sport, gym etc) ?

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F6. Does your bladder problem / prolapse affect your ability to travel? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F7. Does your bladder problem / prolapse limit your social life? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F8. Does your bladder problem / prolapse limit your ability to see / visit friends? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

Personal Relationships

F9. Does your bladder problem / prolapse affect your relationship with partner? YES/NO/NA

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F10. Does your bladder problem / prolapse affect your family life? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

Emotions

F11. Does your bladder problem / prolapse make you feel depressed? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F12. Does your bladder problem / prolapse make you feel anxious or nervous? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F13. Does your bladder problem / prolapse make you feel bad about yourself? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

Sleep / Energy

F14. Does your bladder problem / prolapse affect your sleep? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F15. Does your bladder problem / prolapse make you feel worn out and tired? YES/NO

If yes, how much does this bother you?

○ not at all ○ a little ○ moderately ○ a lot

F16. If you had to spend the rest of your life with your urinary / prolapsed symptoms as they are now, how Would you feel?

a. Perfectly happy b. Pleased c. Mostly satisfied d. Mixed feelings

e. Mostly dissatisfied f. Very unhappy g. Desperate

GYNAECOLOGICAL HISTORY

G1. Are you still having periods? (If after menopause, go to G6) YES/NO

G2. When was your last period? _____

G3. Do you have any problem with your periods? YES/NO

If YES-what kind _____

G4. Are your urinary problems different before/during/after your period? YES/NO

If YES please circle which.

G5. What method of birth control do you use? _____

G6. If you no longer have periods, when did they stop? _____

G7. Have you ever been given HRT (Hormone Replacement Therapy) YES/NO

If YES-when and for how long? _____

G8. Do you often have itching down below? YES/NO

Have you ever had any of the following?

G9. Womb removed (hysterectomy) with a cut on your abdominal wall YES/NO

G10. Womb removed via the vagina (vaginal hysterectomy) YES/NO

G11. One or both ovaries removed YES/NO

G12. Prolapse repair YES/NO

G13. Urinary incontinence surgery YES/NO

G14. Any other kind of gynaecological or pelvic surgery YES/NO

OBSTETRIC HISTORY

G1. How many children do you have?

G2. How many were born by caesarean section?

G3. Have you given birth to a baby weighing inexcess of 9lbs/4kg?

G4. Were any of your children born breech, by forceps or vacuum delivery?

G5. Did you ever have stitches after delivery?

MEDICAL HISTORY

Please give details if you have had any of the following.

Chest / lung problems.
Heart problems.
Stroke / high blood pressure / fits / blackouts / muscle weakness.
Back or neck problems.
Depression / anxiety / panic attacks.
Diabetes.
Any other serious illness.

H1. What medicines do you take?

H2. Are you allergic or sensitive to anything?

SURGICAL HISTORY

H3. Have you ever had **ANY KIND** of surgical operation not already mentioned?
IF YES—what and when.