AWARE WOMEN'S HEALTH

Level 1 / Suite 3 / 257 Melbourne St
North Adelaide SA 5006
Phone 08 8361 7866 Fax 08 8361 7929
reception@awarewomenshealth.com.au
awarewomenshealth.com.au

Prolapse Questionnaire

Please complete this form and return it to the rooms prior to, or at the time of your consultation.

NAME AND CONTACT DETAILS

Name:

Date of birth:

Number of pregnancies:

Number of children:

Weight of heaviest child:

Which best describes your reason for making an appointment:

- ☐ Have symptoms and think that you may have a prolapse
- ☐ Have previously had a prolapse diagnosed & need advice
- ☐ Would like a second opinion

SYMPTOMS

How long have you been experiencing symptoms?

Which of the following symptoms do you experience :

- ☐ Lump at the opening of the vagina
- ☐ Pelvic discomfort or pain
- ☐ Exacerbation of symptoms with prolonged standing
- ☐ Urinary urgency
- ☐ Incomplete bladder emptying
- ☐ Constipation
- ☐ Need to manually assist bowel emptying
- ☐ Lack of sensation with intercourse
- ☐ Sensation of pressure in the vagina
- ☐ Low back pain
- ☐ Urinary incontinence
- ☐ Slow urinary stream
- ☐ Urinary tract infections
- ☐ Pain with bowel motion
- ☐ Pain with intercourse

Have you needed to limit activity because of symptoms? Y / N

PREVIOUS INVESTIGATIONS AND TREATMENT

What kind of health care provider have you previously seen in relation to this problem:

- ☐ GP
- ☐ Gynaecologist
- ☐ Physiotherapist
- ☐ Alternative therapist, please specify:
- ☐ Other, please specify:

TREATMENT EXPECTATIONS

What kind of treatment are you interested in:

- ☐ Pelvic floor rehabilitation
- ☐ Non- surgical options such as ring pessary
- ☐ Surgical correction
- ☐ Lifestyle advise and management strategies