

Name \_\_\_\_\_

Date \_\_\_\_\_

## Pelvic Floor Inventory Questionnaire (PFIQ)

### Instructions

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an “X” in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **during the past three months**.

**You may or may not have symptoms in each of these three areas, but please be sure to mark an answer in all 3 columns for each question.** If you do not have symptoms in one of these areas, then the appropriate answer would be “Not at all” in the corresponding column for that area.

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### Example

For the following question: How do symptoms or conditions related to the following usually affect your ability to do household chores (cooking, house cleaning, laundry)?

If your bladder or urine symptoms affect this *moderately*, your bowel or rectum symptoms affect this *somewhat*, and your vagina or pelvic symptoms *not at all*, you would place an “X” in the boxes as follows:

How do symptoms related to the following → Affect your ↓	Bladder or Urine	Bowel or Rectum	Vagina or Pelvic
Ability to do household chores (cooking, house cleaning, laundry)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input checked="" type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input checked="" type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input checked="" type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

Please turn over this page and complete the questionnaire. *Be sure to answer all three columns for each and every question*, as it relates to your symptoms or condition in the past three (3) months. Thank you!

*Pelvic Floor Inventory Questionnaire (PFIQ), continued*

Name \_\_\_\_\_

Date \_\_\_\_\_

	<b>How do symptoms related to the following → Affect your ↓</b>	<b>Bladder or Urine</b>	<b>Bowel or Rectum</b>	<b>Vagina or Pelvic</b>
1	Ability to do household chores (cooking, house cleaning, laundry)?	<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	Ability to do physical 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 a distance greater than 30 minutes away 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	Feeling frustrated?	<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