

OBGYN-CARE

www.obgyn-care.net

Toll Free: 1-855-obgyn-care  
(1-855-624-9622)

Fax: (949) 642-3621

E-mail: info@obgyn-care.net



Catalin Marinescu, M.D., F.A.C.O.G.

415 Old Newport Blvd., Suite 100

Newport Beach, CA, 92663

Phone: (949) 642-3606

E-mail: marinescu@obgyn-care.net

### Pelvic floor distress inventory

Patient Name: ..... Date of birth: .....

1. Do you usually experience pressure in the lower abdomen? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
2. Do you usually have a bulge or something falling out that you can see or feel in the vagina? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
3. Do you experience a feeling of incomplete bladder emptying? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
4. Do you have to push with your fingers on a bulge in vaginal area to start or complete your urination? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
5. Do you have to push with your fingers on the vagina or around the rectum to have or complete a bowel movement? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
6. Do you need to strain to have a hard bowel movement? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
7. Do you ever lose stool beyond your control? \_\_No \_\_Yes
8. If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
9. Do you usually have pain when you pass stool? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
10. Do you feel pain during the sexual intercourse? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
11. Do you avoid sexual intercourse because bulging in the vagina or fear of incontinence (urine, stool, gas)? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
12. Compared to orgasms you have had in the past, are the orgasms that you had in the past 6 months less intense? \_\_No \_\_Yes  
If yes, how much does that bother you? \_\_Somewhat \_\_ Moderately \_\_ Severe
13. List all medications you have taken in the past six months  
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Patient signature: .....

Date:.....