



POP-RFQ

POP RISK FACTOR QUESTIONNAIRE

Women experiencing pelvic, vaginal, or rectal symptoms that impact their quality of life for at least 3 months may be experiencing pelvic organ prolapse. Print out this questionnaire, answer the questions, and take it to your gynecologist or primary care practitioner for analysis if you feel you are experiencing symptoms of pelvic organ prolapse. Circle the applicable answer.

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|---|-----|----|-------|
| 1. Have you had at least one vaginal birth? If Yes, how many? | Yes | No | _____ |
| 2. Did you experience a long labor, forceps, or suction delivery? | Yes | No | _____ |
| 3. Do you feel or see tissues bulging from your vagina? | Yes | No | |
| 4. Are you in menopause? | Yes | No | |
| 5. Do you leak urine when you sneeze, cough, or laugh? | Yes | No | |
| 6. Do you have difficulty starting your urine stream? | Yes | No | |
| 7. Have you experienced stool leakage? | Yes | No | |
| 8. Do you have chronic constipation? | Yes | No | |
| 9. Do you lift heavy weight at home or work (including children over 30#)? | Yes | No | |
| 10. Do you marathon run, jog, or engage in high energy athletic activities? | Yes | No | |
| 11. Have you had a hysterectomy? | Yes | No | |
| 12. Do you experience chronic coughing? | Yes | No | |
| 13. Do your tampons push out of place? | Yes | No | |
| 14. Do you feel vaginal or rectal pressure? | Yes | No | |
| 15. Is intercourse painful? | Yes | No | |
| 16. Do you have reduced sexual sensation? | Yes | No | |
| 17. Are you double jointed? | Yes | No | |

****This questionnaire is not meant to take the place of treatment from a health care practitioner. Please seek the advice of your physician regarding health concerns. ****

<http://www.pelvicorganprolapsesupport.org>