Bladder Health Questionnaire

1. How often do you urinate during the day? ________
2. How often do you get up at night to urinate? ________
3. Is the amount you usually pass: 1. Large 2. Average 3. Small

Y/N

4. How long have you had urinary problems? ________
5. Do you currently use a pad to protect from urine leakage? ________
6. Have you noticed anything unusual protruding from your vagina? If yes, how long? _______________ ________
7. Do you have a strong sense of urgency to urinate? ________
8. Do you have to hurry to empty your bladder when full? ________
9. Do you ever not make it in time and leak urine? ________
10. Can you overcome the sensation of urgency to urinate? ________
11. Does the sight, sound or feel of water cause you to urinate? ________
12. When you return home from shopping, do you put your groceries away first, or do you go to the bathroom first? ________
13. Do you ever lose urine while lying down? ________
14. Do you have a warning before losing urine? ________
15. When urinating can you stop your stream? ________
16. Do you ever accidently wet the bed while asleep? ________
17. Do you have difficulty starting your urine stream? ________
18. Do you feel that you completely empty your bladder? ________
19. Do you notice dribbling of urine after voiding? ________
20. After you have finished voiding, do you have the urge to void again in a few minutes? ________
21. Have you ever been catheterized because you were unable to void? ________
22. Do you ever see blood in your urine? ________
23. Do you have pain with urination? ________
24. Have you been treated for 3 or more urinary tract infections In the past 3 years? ________
25. Have you been treated for an infection within the past 6 months? ________

26. Have you noticed urine leakage with the following activities?

	Mild (drop)	Moderate (squirt)	Severe (stream)
Sitting			
Standing			
Cough			
Laugh			
Sneeze			
Jogging			
Lifting			
Bending			

27. Do you have any problems with bowel incontinence? _______
28. Are you currently sexually active? (within the last ____months?) _______
29. Do you have any problems with sexual intercourse due to pain, vaginal dryness, prolapsed, other? _______
30. Previous treatments you have utilized for this problem? _______
    1. Kegel exercises to strengthen pelvic floor muscles _______
    2. Medications ____________________________________ _______
    3. Estrogen cream or pills _______
    4. Pessary _______
    5. Diaphragm _______
    6. Physical Therapy _______
    7. Surgery _______

31. Previous medical testing for urinary problems:

Cystoscopy Y N

Urodynamic testing Y N

30. Did your urinary difficulty begin:

During a prior pregnancy _______

After a delivery _______

Following an abdominal/vaginal surgery _______

After menopause _______