

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 you lose urine? _____
15. When urinating can you stop your stream? _____
16. Do you ever accidentally wet the bed while asleep? _____
17. Do you have difficulty starting your urine stream? _____
18. Do you ever 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 ever 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? _____
- Kegel exercises to strengthen pelvic floor muscles _____
 - Medications _____
 - Estrogen cream or pills _____
 - Pessary _____
 - Diaphragm _____
 - Physical Therapy _____
 - Surgery _____
31. Previous medical testing for urinary problems:
- | | | | |
|--------------------|---|---|--|
| Cystoscopy | Y | N | |
| Urodynamic Testing | Y | N | |
32. Did your urinary difficulty begin:
- | | |
|---|--|
| During a prior pregnancy | |
| After a delivery | |
| Following an abdominal/ vaginal surgery | |
| After menopause | |