Center for Advanced Gyn & Urogynecology
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Bladder Satisfaction Survey

Name:_____ Date:_____

Which symptoms best describe you? (check all that apply)

- o Frequent urination- Day, Night, or both
- o Sudden or strong urge to urinate
- o Unable to empty the bladder
- o Leaking with sneezing, coughing, excising
- o Leaking with urge or no warning (unable to make it to the bathroom in time)
- o Bladder or pelvic pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? YES NO

If yes, circle the medications you have tried:

Detrol®LA	**Ditropan XL®**	**Flomax®**	**Cardura®**
Oxytrol® Patch	**Enablex®**	**VESIcare®**	**DDAVP®**
Sanctura®	**Elavil®**	**Elmiron®**	**Other:**

Did these medications help your symptoms? (Circle #)

0	1	2	3	4	5	6	7	8	9	10

No Relief **Completely Cured**

If you've stopped taking your meds explain why: (circle)

Did not help Side Effects Too expensive

Describe side effects:_____

Behavior modifications tried:_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? (Circle #)

0	1	2	3	4	5	6	7	8	9	10

Not frustrated Very frustrated

Do you currently have any problems with bowel function? (Circle all that apply)
Fecal incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications: YES NO