Print in Color or Grayscale Only		der Hea	-										
Using Adobe Acrobat Reader 8.0 or later	Please answ	wer every o	questi	on									
		NT PATIENT'S		JAME			I						
Marking Instructions													
-													
Please use a # 2 pencil		PLEASE PRINT PATIENT'S FIRST NAI				[TIENT'S DATE OF B					
Fill in the complete oval as shown						N	lonth	D	ау		Year		
Height:	Weight:					Age:							
Referring Doctor:		Prim	ary D	octor:									
Please list any known allergies:													
BLADDER HEALTH													
Please answer the following questions reg	arding your blac	dder health	h.										
How often do you urinate during the day?		2-3 times 4-5 times	0			8 tim 2 tim	es 🤇	\geq		mo	re tha	an 12	
How often do you get up at night to urina	te?	2-3 times	0		6-8	8 tim	es 🤇	\sum		mo	re tha	an 12	
		4-5 times	\bigcirc		9-12	2 tim		\sum					
Do you usually have a strong sense of urgency to urinate?						У	es 🤇	<u> </u>			nc		
	or that is relieve		ting?									nc	
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(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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Bladder Health

Please answer every question

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BLADDER HEALTH continued							
How do you start your flow?		ush / strain 🔵 🔳					
W	wait more than o	wait more than one minute 🦳					
Have you been treated for 3 or more urinary infe		yes 🔵	no 🔵				
Have you been treated for a bladder infection w	ithin the last 6 months?	yes 🔵	no 🔵				
BOWEL HEALTH							
Please answer the following questions regarding	your howel health						
riease answer the following questions regarding	your bower nearth.						
How would you describe your bowel movements	s? normal 🔿	constipated O					
Have you ever passed stool when you thought it		yes 🔾	no				
If yes, how often?							
-	occasionally 🔵	twice					
GENERAL HEALTH							
Do you have (or had in the past) any of the follow	wing? (Mark all that apply.)						
			arthritis 🔵 🔳				
heart problems 🦳	sleep apnea 🦳		stroke 🔵 🔳				
back injury 🔵	asthma 🔵	vaginal bulge	(prolapse) 🔵				
multiple sclerosis 🔵	diabetes 🔵		NONE				
WOMEN'S HEALTH							
Women Only: Please answer the following ques	tions regarding your health.						
······································							
How many live births have you had?	ONE (No live births)						
			-				
1 2 3	4 5 6	7 8 9	10				
C-SECTION O							
	4 5 6	7 8 9	10				
NATURAL O							
Did your urinary difficulty begin:							
During a pregnancy?		yes 🔵	no				
Following a pregnancy?		yes O					
		,					
Have you had a hysterectomy?		yes 🔵	no 🔵 🗖				
If yes, was it vaginal?		yes 🔾	no				
Or abdominal?		yes 🔾	no 🔵				
		, _					

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