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Using Adobe Acrobat Reader 8.0 or later

Bladder Health

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Height: _____ **Weight:** _____ **Age:** _____

Referring Doctor: _____ **Primary Doctor:** _____

Please list any known allergies: _____

_____

BLADDER HEALTH

Please answer the following questions regarding your bladder health.

How often do you urinate during the day? 2-3 times ◯ 4-5 times ◯ 6-8 times ◯ 9-12 times ◯ more than 12 ◯

How often do you get up at night to urinate? 2-3 times ◯ 4-5 times ◯ 6-8 times ◯ 9-12 times ◯ more than 12 ◯

Do you usually have a strong sense of urgency to urinate? yes ◯ no ◯

Do you have pain or pressure in the bladder that is relieved by urinating? yes ◯ no ◯

Can you postpone emptying your bladder easily? yes ◯ no ◯

Can you overcome the sensation of urgency to urinate? yes ◯ no ◯

Is your urinary flow intermittent (stop and go)? yes ◯ no ◯

Does the sight, sound, or feel of running water cause you to lose your urine? yes ◯ no ◯

Describe the nature of your leak. *(Mark all that apply.)*

- leak with coughing, sneezing, jumping, running, or lifting ◯
- leak with intercourse ◯
- continuous leakage ◯
- leak with urge (desire to void) ◯
- leak without awareness ◯
- not applicable (no leakage) ◯
- other ◯

How much do you leak?

- drops ◯
- wet pants ◯
- "flood" (to the floor) ◯
- not applicable (no leakage) ◯

Do you find it necessary to wear protection because you get wet from the urine that you lose? yes ◯ no ◯

If yes, how many pads do you use daily?

1-2 pads ◯ 3-4 pads ◯ 5-6 pads ◯ 7-8 pads ◯ more than 8 pads ◯

Do you change the pad when it is: damp ◯ soaked ◯

When urinating, can you usually stop your stream? yes ◯ no ◯

Do you ever accidentally wet the bed at night while asleep? yes ◯ no ◯

If yes, how often?

- rarely ◯
- once a week ◯
- more than twice a week ◯
- occasionally ◯
- twice a week ◯
- nightly ◯

Do you feel that you completely empty your bladder? yes ◯ no ◯

Do you notice dribbling of urine when you stand after urinating? yes ◯ no ◯

Were you ever catheterized because you were unable to void? yes ◯ no ◯

Have you ever been treated by urethral dilations? yes ◯ no ◯

Do you ever pass blood in your urine? yes ◯ no ◯

Have you ever passed sand, gravel, or stones? yes ◯ no ◯

Do you have pain during urination? yes ◯ no ◯

Do you have difficulty starting your stream? yes ◯ no ◯

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Bladder Health

Please answer every question

BLADDER HEALTH continued

How do you start your flow?	easy ◯	push / strain ◯
	wait less than one minute ◯	wait more than one minute ◯
Have you been treated for 3 or more urinary infections?	yes ◯	no ◯
Have you been treated for a bladder infection within the last 6 months?	yes ◯	no ◯

BOWEL HEALTH

Please answer the following questions regarding your bowel health.

How would you describe your bowel movements?	normal ◯	constipated ◯	loose ◯
Have you ever passed stool when you thought it might be gas?		yes ◯	no ◯
If yes, how often?	once ◯		twice ◯
	occasionally ◯		often ◯

GENERAL HEALTH

Do you have (or had in the past) any of the following? *(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 questions regarding your health.

How many live births have you had? ◯ **NONE (No live births)**

	1	2	3	4	5	6	7	8	9	10
C-SECTION	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
NATURAL	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Did your urinary difficulty begin:		
During a pregnancy?	yes ◯	no ◯
Following a pregnancy?	yes ◯	no ◯
Have you had a hysterectomy?	yes ◯	no ◯
If yes, was it vaginal?	yes ◯	no ◯
Or abdominal?	yes ◯	no ◯