Bladder Health History Questionnaire

To all my patients: In my ongoing effort to provide excellence in women's health care, I am requesting all patients to please complete the following. Sometimes personal things are hard to talk about, but I would like to have this information as a permanent part of your record. **All information is confidential.**

1: Do you leak urine during a cough, sneeze, laugh, or any other physical activity?..... Y / N
2: Are there other types of activities that cause this to occur? _____
_____
3: Immediately after you finish urinating, do you feel the need to urinate again?..... Y / N
4: Do you sometimes dribble just prior to, or just after urinating? ..... Y / N
5: Do you leak spontaneously without warning? ..... Y / N
6: Do you ever have sudden urges to urinate? ..... Y / N
7: Do you leak if you have a sudden urge? ..... Y / N
8: Do you use protective pads or diapers? ..... Y / N
9: If so, how many per day? None 1-3 4 + Varies Type used_____
10: Have you ever tried Kegel exercises, Biofeedback, or another non-surgical treatment... Y / N
11: Do you have frequent urinary tract infections? ..... Y / N
12: Have you ever had Blood in your urine? ..... Y / N
13: Do you have pain when you urinate? ..... Y / N
14: Does your urinary problem interfere with your daily activities? ..... Y / N
15: Does your urinary problem interfere with your sexual activity? ..... Y / N
16: Do you get up at night to urinate? ..... Y / N
17: Do you ever leak urine at night? ..... Y / N
18: Do you have children? ..... Y / N
19: Have you completed your child bearing? ..... Y / N
20: Were your children delivered by C-section? ..... Y / N
21: Have you ever had a Gynecological or Urological surgical procedure? Such as a Bladder Suspension or Hysterectomy? ..... Y / N
22: Have you had Radiation treatment of the pelvis? ..... Y / N
23: If you had a Hysterectomy, was it performed through an Open Incision? ..... Y / N
24: If Yes, were your Ovaries removed at the time of the Hysterectomy? ..... Y / N
25: If Yes, Are you taking Hormone Replacement Therapy? ..... Y / N
26: Do you currently smoke? Or have you smoked in the past? ..... Y / N
27: How many times do you experience Incontinence Episodes in a day? 0 1-3 4+
28: How long ago were your first experiences of Incontinence? _____
29: Are you taking any Medication? Or, Over the Counter Drugs for this problem? Please list if any _____
_____
30: Would you like more information about the new treatments available? .....Y / N