

Symptom Questionnaire

Name: _____ DOB: ___/___/___

Describe the reason for your appointment: _____

When did this problem begin? _____ Is it getting better? _____ worse? _____ staying the same? _____

List activities or things that you cannot do because of this problem: _____

Bladder leakage frequency – number (#) of episodes

- Never
- Only with strong cough/sneeze
- Only premenstrual
- ___ # per month
- ___ # per week
- ___ # per day

Severity of leakage (Check one)

- No leakage
- Few drops
- Wets underwear
- Wets outerwear

Protection worn (Check One)

- None
- Tissue paper / paper towel
- Pantishields
- Minipads
- Maxipads
- Specialty product name _____
- Diaper

Leakage caused or increased by (Check all that apply)

- Vigorous activity or exercise (running, weight lifting)
- Light activity (walking, light housework)
- Changing positions (sit to stand)
- Walking to the toilet
- Strong urge to go
- Intercourse or sexual activity
- No activity changes leakage (constant despite activity)
- Other, please list _____

Rate your feeling as to the severity of this problem from 0-10 with 10 being the worst

0--- -----10

Not a problem Major problem

Rate the following statement as it applies to you today.

0--- -----10

Not true at all Completely true

Position or activity with leakage. (Check all that apply)

- Lying down
- Sitting
- Standing

How long can you delay the need to urinate? (check one)

- Not at all
- 1-2 minutes
- 3-10 minutes
- 11-30 minutes
- 31-60 minutes
- ___ hours

Rate feeling of "falling out" or pelvic heaviness/pressure

- None present
- ___ times per month
- Only with menstruation
- standing
- With exertion or straining
- At the end of each day
- Present all day

Fluid intake (one glass is 8 oz or one cup)

- ___ glasses per day
- # of caffeinated glasses ___ per day
- # of alcoholic beverages ___ per day

Bladder Habits

How often do you urinate during the day? ___ # of times

How often do you urinate after going to bed? ___ # of times

Do you take your time to go to the toilet and empty your bladder? Yes No

Number of bladder infection in the last year? ___

Can you stop the flow of urine when on the toilet? Yes No

Is the volume of urine passed usually; Large Average Small Very Small

Do you have the sensation that you need to go to the toilet? Yes No

Do you strain to pass urine? Yes No

Do you empty your bladder frequently, before your experience the urge to pass urine? Yes No

Do you have the feeling you bladder is still full after urinating? Yes No

Do you have a slow or hesitant urinary stream? Yes No

Do you have difficulty initiating the urine stream? Yes No

Do you have "triggers" that make you feel like you can't wait to go to the toilet (running water, etc)? Yes No

Please list _____

Bowel Habits

Frequency of bowel movements ___ per day ___ per week

Consistency of stool loose normal hard

History of constipation? Yes No

Do you currently strain to go? Yes No

Do you ignore the urge to defecate? Yes No

Do you have trouble making it to the toilet on time when you have an urge to go? Yes No