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URINARY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____

What is your primary reason for having this evaluation done? _____

_____

_____

Have you ever had an evaluation for urine loss before? ..... Yes No

If yes, When _____ Where _____

VOIDING

How many trips to the bathroom do you make during the ..... day? _____ night? _____
Is the amount of urine usually (circle one) ..... large average small

Do you have difficulty starting your urinary flow? ..... Yes No
When urinating, are you unable to stop your stream? ..... Yes No
Do you strain to urinate? ..... Yes No
Is the urine flow (circle one): ..... strong weak intermittent

Do you feel that you CAN'T empty your bladder completely? ..... Yes No
Do you notice dribbling of urine after voiding? ..... Yes No
Do you have to assume abnormal positions to urinate? ..... Yes No

URINE LOSS

Do you lose urine (incontinence)? ..... Yes No
Duration of incontinence ..... _____ years _____ months
Would you describe the amount of urine that you lose as being:
- frequent small volumes? ..... Yes No
- unconscious / continuous loss (always damp or wet)? ..... Yes No
- infrequent but single large volumes of loss? ..... Yes No

Incontinence due to coughing, laughing, running etc.? ..... Yes No
Do you lose your urine during intercourse? ..... Yes No
Do you need to wear protective "pads" because of incontinence? ..... Yes No
How many pads do you usually use per day for protection? ..... 0 1 2 3 4 5 6 7 8 more

URGENCY

Are you bothered by a strong sense of urgency to void? ..... Yes No
Do you find you CAN'T overcome the sensation of urgency to void? ..... Yes No
Do you sometimes not make it to the bathroom in time (urgency with loss)? ..... Yes No
Do you lose urine without warning (without activity or feeling the urgency)? ..... Yes No
What activities cause you to unexpectedly lose control of your urine?
- sight, sound or feel of running water? ..... Yes No
- standing up after being seated or lying down? ..... Yes No
- "key in the door" when you come home? ..... Yes No

Do you ever wet the bed while asleep? ..... Yes No

(More Questions on Reverse Side)

IMPACT

Has urine leakage limited your ability to:	No	Min.	Mild	Mod.	Greatly
- do household chores (cooking, cleaning, laundry)?	0	1	2	3	4
- have physical recreation (walking, swimming, other exercise)?	0	1	2	3	4
- participate in activities (church, movies, concerts)?	0	1	2	3	4
- travel more than 30 minutes from home?	0	1	2	3	4
- participate in social activities outside your home?	0	1	2	3	4
- participate in, enjoy or feel comfortable with sexual activity?	0	1	2	3	4

Do you have (circle all that apply)?

Loss of self-esteem / Depression / Frustration / Nervousness

INFECTION

Do you have frequent urinary infections? ..... Yes No

How many urinary infections per year? ..... 1 2 3 4 more (per year)

Do you ever see blood in your urine? ..... Yes No

PAIN

Do you have pain with urination? ..... Yes No

Do you have pain in the lower abdomen? ..... Yes No

Is the pain related to:

- your bladder being full? ..... Yes No
- your menstrual cycle? ..... Yes No
- intercourse? ..... Yes No
- bowel movements? ..... Yes No

Do you have a feeling of vaginal fullness or pressure? ..... Yes No

Can you see or feel a swelling protruding from the vagina? ..... Yes No

- Do you push the protrusion back to help have a bowel movement or to empty your bladder? ..... Yes No

Are you sexually active? ..... Yes No

- if **No**, is it due to:
  - vaginal problems (with lubrication or pain)? ..... Yes No
  - partner problems (impotent, widowed, divorced)? ..... Yes No

Is sexual activity an important consideration in how we help your issue? ..... Yes No

HISTORY

Have you had surgery on your spine, brain, or bladder? ..... Yes No

Have you had kidney stones or kidney disease? ..... Yes No

Did you have difficulty holding your urine as a child? ..... Yes No

Did you wet your bed as a child? ..... Yes No

Do you need to use a catheter to help pass urine? ..... Yes No

Do you have problems with constipation? ..... Yes No

Have you ever had (circle all that apply)?

paralysis / polio / multiple sclerosis / a back injury / a cyst or tumor on your spine
tuberculosis / a stroke / syphilis / diabetes / pernicious anemia / neurologic disease or disorder

Did your urine problems start after (circle)?

Delivery of a baby / Hysterectomy / Vaginal surgery / Other surgery / Menopause