Bladder Health Questionnaire

Please bring this form with you on the day of your appointment.

Name_____ Date_____Allergies_____

How often do you urinate during the day/evening? _____
How often do you get up at night to urinate? _____
When did your bladder problems begin?_____
Do you usually have a strong sense of urgency to urinate? Yes No
Do you experience pain when your bladder is full? Yes No
Can you postpone emptying your bladder easily? Yes No

Do you lose urine when : you are lying down or asleep? Yes No
you sneeze, cough, jump, run, laugh? Yes No
you get up from a sitting position? Yes No
you hear, see or feel running water? Yes No
you can't get to bathroom on time? Yes No
you don't even know it? Yes No
Do you wear protection for urinary leakage? Yes No
If yes, do you use __pantyliners__shield type pads__briefs__underwear
If yes, how many do you wear per day? _____
Do you have difficulty starting your urine stream? Yes No
How do you start your urine stream? ____ easy ____ push/strain
____ wait less then 1 minute ____ wait more than 1 minute
Do you have pain when emptying your bladder? Yes No
When urinating, can you stop your stream? Yes No
Do you feel you have completely emptied your bladder? Yes No
Do you notice dribbling of urine after emptying your bladder? Yes No
Have you ever have a tube placed in your bladder because you were unable to empty your bladder? Yes No
Have you ever had your urethra dilated or stretched? Yes No
Have you ever-passed blood in your urine? Yes No
Have you ever had a kidney or bladder stone? Yes No

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Have you been treated for 3 or more urinary tract infections? Yes No
Have you had an infection within the last 6 months? Yes No
Do you leak gas or stool? Yes No
Are you constipated? Yes No
If you are a female, how many pregnancies have you had?_____
Vaginal deliveries_____ C-Section deliveries_____ Miscarriages_____

What treatments for your bladder problems have you tried in the past?
___ Kegel exercises ___ Pessary insertion ___ fluid/diet changes
___ Medications-list them _____
___ Surgery (list below) ___ Collagen injections

List all of the medications you have been taking over the last 6 months:

_____

_____

_____

_____

Do you take aspirin?___yes ___no If yes, how often?_____

List all of the surgeries you have had and the dates of each:

_____

_____

_____

_____

Do you have the following? Please circle all that apply:

Heart problems
High blood pressure
Asthma
Arthritis
Back injury (when and what)_____
_____
Multiple sclerosis
Diabetes
Stroke
Other_____

HEALTHSOUTH
Medical Center

Urodynamics Center "Uro-Log" (Voiding Diary)

To be completed before your doctor's appointment.

Name _____ Date _____

Time of Day	Type and Amount of Fluid Intake TYPE/AMT		Amount Voided (in ounces)	Amount of Leakage (small, medium, large)	Activity Engaged in When Leakage Occurred	Was Urge Present? YES/NO
8 a.m.				S M L		Y N
9 a.m.				S M L		Y N
10 a.m.				S M L		Y N
11 a.m.				S M L		Y N
12 p.m.				S M L		Y N
1 p.m.				S M L		Y N
2 p.m.				S M L		Y N
3 p.m.				S M L		Y N
4 p.m.				S M L		Y N
5 p.m.				S M L		Y N
6 p.m.				S M L		Y N
7 p.m.				S M L		Y N
8 p.m.				S M L		Y N
9 p.m.				S M L		Y N
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