



tending to the unique nature of women

Urinary Incontinence Questionnaire			
Name:	SSN:	Date:	
Age:	# of Vaginal Deliveries:	Height:	Weight:

General
1. Do you have any medical problems that require regular doctor visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please describe: _____
2. Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have heart disease, a heart murmur, or mitral valve prolapsed? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you take antibiotics prior to dental exams or visits to your dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. What current medications do you take? _____
6. Have you ever had any operations on your pelvic organs (bladder, urethra, uterus, tubes, ovaries, rectum, appendix or colon)? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever injured your back or had back surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you have any problems with your spinal cord or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. How much urine do you leak? _____ Do you have to wear a pad or change clothes as a result of urine leakage? <input type="checkbox"/> Yes <input type="checkbox"/> No How often do you change it? _____
10. What are you most often doing when you leak urine? _____
11. Does leaking of urine prevent you from performing any desired activities? <input type="checkbox"/> Yes <input type="checkbox"/> No If so what are they? _____
12. Do you have a chronic cough? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how much? _____
14. Are you planning on having more children? <input type="checkbox"/> Yes <input type="checkbox"/> No

Detrusor Instability
15. What type of stimuli (i.e. running water) gives you the urge to urinate? _____
16. Do you ever have such a strong urge to urinate that if you don't reach the toilet immediately you leak? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Do you ever leak before you reach the toilet? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. How many times do you have to get up at night to urinate? _____
19. Do you ever wet the bed? <input type="checkbox"/> Yes <input type="checkbox"/> No
20. Do you ever spontaneously leak urine? <input type="checkbox"/> Yes <input type="checkbox"/> No
21. Are there periods of time, such as a week or two, when you do not leak? _____

Stress Incontinence
22. Do you leak urine when you cough, sneeze, laugh, or exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No

23. Is there just a few seconds' delay between such activity and leaking? Yes No

Injection

24. Does it burn or sting when you urinate? Yes No

25. Do you have difficulty starting your urine flow? Yes No

26. Do you feel as if you need to void but are unable to empty your bladder? Yes No

Urinary System Pathology

27. Have you had frequent bladder or kidney infections? Yes No

28. Have you ever had blood in your urine in the past year? Yes No

29. Do you ever continue dribbling after you urinate? Yes No

Bowel Function

30. Do you have any difficulty with your bowel movements? Yes No

31. Are you incontinent of flatus or stool? Yes No

32. Do you have to press in or on the front of your vagina to move your bowels? Yes No

33. Are you often constipated or forced to strain to move your bowels? Yes No