

Incontinence Symptom Questionnaire

Have you experienced menopause? Yes No

If YES:

Date of Menopause _____

Are you taking estrogen replacement (ERT)?

Yes No

When did you begin ERT? (m/d/y)

Have you been taking ERT for at least 3 months at this time?

If NO:

Date of last menstrual period _____

days of menstrual flow _____

days between periods _____

Excessive bleeding? Yes No

Irregular Bleeding? Yes No

Are you planning more children? Yes No

Contraceptive Method? _____

Date last mammogram _____

Date last PAP smear _____

Other gynecologic condition(s)

Have you had a hysterectomy? Yes No If Yes, give date _____

Reason for hysterectomy: _____

Was hysterectomy done through vagina or abdominal incision? Vagina Abdominal Incision

Were the ovaries removed? Both One Not at all

Have you had any bladder repairs? Yes No

Describe repairs Date of repair

_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

List all other surgeries and hospitalizations with the date (M/D/Y)

Dates

List all medications that you are currently taking.

Please include over the counter drugs, vitamins and herbal remedies

Dosage

Schedule

_____	_____
_____	_____
_____	_____
_____	_____



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List all medications to which you are allergic:

Are you allergic to latex? Yes No X-ray dye? Yes No

Have your medications changed in the last 6 months? Yes No

If yes, please describe changes

Medications you have used in the past to control incontinence

Was the medication helpful?

- | | |
|--|--|
| <input type="checkbox"/> Detrol (Tolterodine) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ditropan (Oxybutynine) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Levsin, Levsinex, Cystospas (Hyoscyamine) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Tofranil (Imipramine) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> ProBanthine (propantheline) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Urispas (Flavoxate) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ornade | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Sudafed (pseudoephedrine) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> DDAVP (desmopressin) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you have a history of any of the following conditions?

Diabetes Yes No

High Blood Pressure Yes No

Heart Disease Yes No

Stroke Yes No

Neurologic Disease Yes No

Osteoporosis Yes No

Psychiatric Disease Yes No

Do you have a heart condition that requires you to take antibiotics prior to procedures? Yes No

Glaucoma Yes No

Prior Back Injury Yes No

Chronic back pain Yes No

Other medical conditions:

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UROLOGIC SYMPTOMS

Do you experience leakage with these activities? (check all that apply)

Lifting Bending over Coughing Sneezing Laughing Walking Running

How often does this type of leak occur? (write in number of times per day, week, or month)

_____ / day _____ / week _____ / month Never

How much urine do you usually lose?

Few drops Soaks underwear Soaks minipad Soaks maxipad Soaks diaper

When you need to urinate, how often is the feeling of urgency so intense that you must rush to the toilet?

Always Often Half the time Occasionally Never

Do you experience leakage with these activities? (check all that apply)

While going to the toilet When unlocking the front door
 With sight or sound of running water When going out into cold weather
 Changing position from sitting to standing

How often does this type of leakage occur? (write in number of times per day, week, or month)

_____ / day _____ / week _____ / month Never

How much urine do you usually lose?

Few drops Soaks underwear Soaks minipad Soaks maxipad Soaks diaper

How often do you usually need to urinate during the day?

Every ___ minutes Every ___ hours

Do you urinate more frequently than you need to in order to prevent leakage? Yes No

What is the longest time that you can hold your bladder? _____ Minutes _____ Hours

How many times must you get up at night to empty your bladder? _____

Is it difficult to start your urine stream? Must you wait or strain?

Always Often Half the time Occasionally Never

Does the urine flow in a good stream or interrupted spurts?

Good Stream Spurts

Does it take a long time to empty your bladder?

Always Often Half the time Occasionally Never

Once the urine stream is started, can you stop it midstream?

Always can Sometimes can Can't stop Haven't tried

Do you feel that you can empty your bladder completely?

Always Often Half the time Occasionally Never

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Do you have to double void (urinate, stand up, then urinate again) to empty your bladder?

Always Often Half the time Occasionally Never

After you have urinated, do you lose urine as you walk away from the toilet?

Always Often Half the time Occasionally Never

Have you every had to use a catheter to drain your bladder? Yes No

Do you lose urine without warning if you are lying still?

Always Often Half the time Occasionally Never

Do you lose urine with a continual drip so that you are always wet?

Always Often Half the time Occasionally Never

Can you feel when you wet yourself?

Always Often Half the time Occasionally Never

Do you wet the bed at night? Yes No How many nights per week does this occur? _____

Did you wet the bed as a child? Yes No If yes, until what age? _____

Do you have frequent urinary tract infections? Yes No If Yes, how many in the last year? _____

Do you have burning pain when you urinate?

Always Often Half the time Occasionally Never

Do you have a constant sensation of the need to void?

Always Often Half the time Occasionally Never

Do you have pain in the area of your bladder?

Always Often Half the time Occasionally Never

Do you experience bulging or protrusion in the vaginal area?

Always Often Half the time Occasionally Never

Do you experience pelvic discomfort when standing or during physical exertion?

Always Often Half the time Occasionally Never

Do you experience low back pain when standing or during physical exertion?

Always Often Half the time Occasionally Never

Do you have to push on the vaginal walls in order to empty your bladder?

Always Often Half the time Occasionally Never

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BOWEL SYMPTOMS

How often do you have a bowel movement? _____/day _____/week

Do you have constipation?

Always Often Half the time Occasionally Never

Do you have diarrhea?

Always Often Half the time Occasionally Never

Do you have difficulty in controlling passing of bowel gas?

Always Often Half the time Occasionally Never

Do you have difficulty controlling your bowels when you have diarrhea?

Always Often Half the time Occasionally Never

Do you have difficulty controlling your bowels when your stools are solid?

Always Often Half the time Occasionally Never

Can you feel the difference between gas or solid stool before you pass it?

Always Often Half the time Occasionally Never

Do you have difficulty emptying your bowels completely?

Always Often Half the time Occasionally Never

Must you strain very hard in order to have a bowel movement?

Always Often Half the time Occasionally Never

Do you have to push on the vaginal walls to have a bowel movement?

Always Often Half the time Occasionally Never

Do you experience urine leakage with sexual activity? Yes Not sexually active

If Yes, when does it occur? During arousal During Intercourse With Orgasm Afterward

If Yes, has this affected your sexual interest? Yes No

Is sexual activity painful? Yes No

What bothers you most about your bladder problems? Please describe.

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PERSONAL COST OF INCONTINENCE

Do you wear protection because of urinary leakage?

- Always Daytime at home Daytime outside home While asleep Never

What items do you use? (complete information below)

List each type of disposable pad by brand name, cost per box and number of pads in each box

Disposable Pad Brand Name	#/day	#/night	Cost/box	#/box
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Towels/washcloths _____#/day and _____#/night

Washable pads _____#/day and _____#/night

Washable Pad Brand Name	Cost/pad	# pads	How many months do they last?
_____	_____	_____	_____
_____	_____	_____	_____

How often do you change clothes because of urinary incontinence per week? _____/week

How many extra loads of laundry (i.e. washable pads, towels, washcloths, bedding, extra clothing changes) must you do because of urinary incontinence per week? _____/week

Estimate the cost per week of skin care products because of urinary incontinence? _____/week.

Have you had to purchase any of the following equipment to manage your incontinence?

Bedside commode? Yes No Estimated cost _____

Special Bedding? Yes No Estimated cost _____

Installation of bars in toilet? Yes No Estimated cost _____

Othr equipment? Yes No Estimated cost _____
(specify _____)?

How much do you pay per month for medication to control incontinence? _____

How many times have you seen a health provider for your incontinence
During the past year? _____

Describe any other costs related to your incontinence

