BLADDER HEALTH QUESTIONAIRE

1. How often do you urinate during the day? _____
2. How often do you get up at night to urinate? _____
3. Is the amount of urine you usually pass: Small Large Average
4. Do you usually have a strong sense of urgency to urinate? NO YES
5. Do you have to hurry to empty your bladder when full? NO YES
6. Do you ever not make it in time and leak urine? NO YES
7. Can you overcome the sensation of urgency to urinate? NO YES
8. Does the sight, sound or feel of running water cause you to lose your urine? NO YES
9. Do you ever lose urine when lying down? NO YES
10. When urinating, can you usually stop your stream? NO YES
11. Do you accidentally wet the bed while asleep? NO YES
12. Do you have difficulty starting your urine stream? NO YES
13. Do you feel that you completely empty your bladder? NO YES
14. Do you notice dribbling of urine after voiding? NO YES
15. Were you ever catheterized because you were unable to void? NO YES
16. Have you ever had your urethra dilated or stretched? NO YES
17. Do you ever pass blood in your urine? NO YES
18. Have you ever passed sand, gravel or stones? NO YES
19. Do you have pain during urination? NO YES
20. Have you been treated for 3 or more urinary infections? NO YES
21. Have you been treated for an infection within 6 months? NO YES

22. Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running?

NO YES

23. Do you find it necessary to use some type of protection? NO YES

24. Did your urinary difficulty begin:

A. During a pregnancy? NO YES
B. Following a delivery? NO YES
C. Following an abdominal or vaginal operation? NO YES
D. After the menopause? NO YES

25. List all the medications you have taken in the past 6 months. Circle those medications you are presently taking.

_____

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Patient's Signature:

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