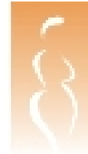
The Women's HEALTH GROUP, P.C. 

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INCONTINENCE QUESTIONNAIRE

Understanding Your Symptoms
There are several types of bladder control problems. Your doctor has given you this diary in order to gain a better understanding of your condition. Once the cause of your problem is determined, your doctor can help you get the proper treatment. So take a few minutes and fill out the next few pages. It will provide your doctor with important information about your symptoms and medical history. Also included is a 3-day diary. You should fill this out as accurately as possible each day for the next three days. Most people find it helpful when they write down the events as they happen. After you have completed this diary, bring it back to your doctor.

Bladder Health Questionnaire

1. How often do you urinate during the day? ______________________________

   How often do you get up at night to urinate? ______________________________

   Do you go to the bathroom more than 8 times per 24 hours? Yes No

   Do you get up 2 or more times during the night to go to the bathroom? Yes No

   How long have you had these symptoms ______________________________ year(s)?

   Is the amount of urine you usually pass: Large? Average? Small?

2. Do you usually have a strong sense of urgency to urinate? Yes No

   Do you have to hurry to empty your bladder when full? Yes No

   Do you ever not make it in time and leak urine? Yes No

   Are you unable to overcome the sensation of urgency to urinate? Yes No

   Does the sight, sound or feel of running water cause you to lose your urine? Yes No

   Do you ever lose urine when lying down? Yes No

   Do you have a warning before losing urine? Yes No

   Do you often look for a bathroom when you're in a new location? Yes No

   When urinating, are you unable to stop your stream? Yes No

   Do you ever accidentally wet the bed while sleeping? Yes No

3. Do you have difficulty starting your urine stream? Yes No

Does your bladder feel full even after you go to the bathroom? Yes No

Do you notice dribbling of urine after voiding? Yes No

4. Were you ever catheterized because you were unable to void? Yes No

Have you ever had your urethra dilated or stretched? Yes No

Do you ever pass blood in your urine? Yes No

Have you ever passed sand, gravel or stones? Yes No

Did your symptoms come on suddenly? Yes No

Do you have pain during urination? Yes No

Have you been treated for three or more urinary infections? Yes No

Have you been treated for an infection within six months? Yes No

5. Do you experience a loss of urine when you are doing physical activities, such as lifting heavy objects, jumping or running? Yes No

Do you have a slight loss of urine when you sneeze, cough or laugh? Yes No

Do you find it necessary to use some type of protection? Yes No

6. I have/had these medical problems: (circle)

Cancer	Constipation	Arthritis	Depression
Stroke	Urinary Infection	Diabetes	Spinal Cord injury
Diverticulitis	Multiple Sclerosis	Interstitial Cystitis	Other ____________

I smoke cigarettes Yes No

Bladder Control Diary -- Day 1

Complete one page for each of the next 3 days. In order to keep the most accurate diary possible, you'll want to keep it with you at all times and write down the events as they happen.

Time	**Fluids**		**Did You Urinate?**			**Accidents**			
	What did you drink? How much?	How many times?	How much each time? small, med, large	Did you feel a strong sudden urge to urinate?		Did you have an accident?		How much urine did you leak?	What were you doing at the time?
SAMPLE	Coffee-1 cup	1	small	Yes	***No***	***Yes***	No	medium	sneezing
SAMPLE		1	large	***Yes***	No	Yes	***No***	/	/
6-8am				Yes	No	Yes	No		
8-10am				Yes	No	Yes	No		
10am-12				Yes	No	Yes	No		
12-2pm				Yes	No	Yes	No		
2-4pm				Yes	No	Yes	No		
4-6pm				Yes	No	Yes	No		
6-8pm				Yes	No	Yes	No		
8-10pm				Yes	No	Yes	No		
10pm-12				Yes	No	Yes	No		
12-2am				Yes	No	Yes	No		

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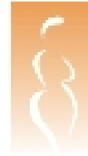

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2-4am				Yes	No	Yes	No		
4-6am				Yes	No	Yes	No		

Bladder Control Diary -- Day 2

Time	Fluids		Did You Urinate?			Accidents			
	What did you drink? How much?	How many times?	How much each time? small, med, large	Did you feel a strong sudden urge to urinate?		Did you have an accident?		How much urine did you leak?	What were you doing at the time?
6-8am				Yes	No	Yes	No		
8-10am				Yes	No	Yes	No		
10am-12				Yes	No	Yes	No		
12-2pm				Yes	No	Yes	No		
2-4pm				Yes	No	Yes	No		
4-6pm				Yes	No	Yes	No		
6-8pm				Yes	No	Yes	No		
8-10pm				Yes	No	Yes	No		
10pm-12				Yes	No	Yes	No		
12-2am				Yes	No	Yes	No		
2-4am				Yes	No	Yes	No		
4-6am				Yes	No	Yes	No		

Bladder Control Diary -- Day 3

Time	Fluids		Did You Urinate?			Accidents			
	What did you drink? How much?	How many times?	How much each time? small, med, large	Did you feel a strong sudden urge to urinate?		Did you have an accident?		How much urine did you leak?	What were you doing at the time?
6-8am				Yes	No	Yes	No		
8-10am				Yes	No	Yes	No		
10am-12				Yes	No	Yes	No		
12-2pm				Yes	No	Yes	No		
2-4pm				Yes	No	Yes	No		
4-6pm				Yes	No	Yes	No		
6-8pm				Yes	No	Yes	No		
8-10pm				Yes	No	Yes	No		
10pm-12				Yes	No	Yes	No		
12-2am				Yes	No	Yes	No		
2-4am				Yes	No	Yes	No		
4-6am				Yes	No	Yes	No		