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Urinary Incontinence Symptom Questionnaire

Name________________________________ Date________________

1. Do you have trouble with your bladder, or do you have trouble holding your urine (water)?
   Yes___No___
2. Do you ever lose urine when you don't want to? Yes___No___
   If yes – For how long have you had this problem? _________ years
   Do you have leakage of urine in the day? Yes___No___
   in the night? Yes___No___
3. Do you ever wear a pad or other protective device to collect your urine? Yes___No___
   If yes – how many pads must you use per day? ______
4. How many cups of coffee or tea do you drink per day? ______
   How many glasses of liquid per day? ______
5. Have you had difficulty recently with constipation? Yes___No___
6. Have you had previous evaluation for incontinence? Yes___No___
   If yes, by whom: ____
   What treatments have been tried? ____
   ____
   Have you had previous surgery? Yes___No___
   What was done and when? ____
   ____
7. Have you ever been told you have a "dropped bladder"? Yes___No___
8. Do you feel as though you have trouble getting the urine to flow? Yes___No___
9. Do you feel you have trouble emptying your bladder completely? Yes___No___
10. Do you *often – sometimes – never* have loss of urine after you have a feeling of urgently having to urinate? (*please circle answer*)
11. Do you have loss of urine with *coughing, sneezing, walking, exercising, lifting or laughing*?
    Yes___No___ (*Please circle which activities cause loss of urine*)

Name______________________________________ Date___________________

12. How many children have you given birth to? _____ How many by c-section? _____
13. Did you have any surgery or change in medicines at the time you started this problem?
    Yes___No___ If yes, please describe: ___________________________________

    ____
14. Do you have any problems getting to the bathroom in time due to physical limitation?
    Yes___No___
15. Have you had problems with urinary tract or bladder infections in the past few years?
    Yes___No___
16. When you have loss of urine, is it usually a small amount each time or a large amount?

    ____
17. Do you have diabetes? Yes___No___

    If yes, do you take insulin? Yes___No___

    If yes, have you had peripheral neuropathy or numb feet? Yes___No___

    If yes, have you retinopathy? Yes___No___
18. Have you ever seen blood in you urine? Yes___No___
19. Have you ever had any neurologic problem such as herniated disk, multiple sclerosis, Parkinson's disease, stroke, numbness, weakness, or paralysis? Yes___No___
20. Enter any other comments relative to this problem.

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