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Lower Urinary Tract Hypersensitivity Questionnaire

Name_____ dob _____

Please circle your answers and add comments as appropriate.

1. What were your bladder habits before your urination discomforts began (frequent urination, burning with urination, urine leakage, or incontinence)? _____

2. Do you have a childhood history of urinary infections, daytime frequency, incontinence, or bedwetting? Yes No If Yes, were any procedures such as a urethral dilation performed to correct such problems? Yes No

3. When your symptoms first began:
   Had you become sexually active? Yes No
   Had a new sexual partner? Yes No
   Changed birth control pills? Yes No
   Changed jobs? Yes No
   Had increased job or school stress? Yes No
   Experienced the start of menopause? Yes No
   Had a minor or major pelvic surgery? Yes No
   Vacationed in a hot environment? Yes No

4. Are your symptoms the same 24 hours per day, 7 days per week? Yes No
If no, how do they vary? _____

5. How often do you urinate during the day at your best? (i.e. once every _____)
at your worst? _____. How often do you urinate at night at your best? _____

6. Rate your pain and urgency on a scale of 0 for no pain or no urgency to 10 for the worst pain or urgency imaginable: pain: ____ urgency: _____

7. Describe your pains: sharp – aching – burning – spasmotic – cramping

8. Where is the pain: lower abdomen – above the pubic bone – groin – clitoris – urethra – vagina – rectum – lower back?

9. Is the pain made worse by a full bladder? Yes No
   Is it relieved with urination? Yes No
   Does it feel better or worse to actually pass the urine? Yes No
   Is the pain worse immediately after the urination? Yes No

10. Is intercourse painful? Yes No
   Is the pain with initial insertion, deep penetration, or both?
   Has the frequency of intercourse changed since the start of this symptom complex? Yes No
   Has your relationship with your partner changed because of your symptom complex? Yes No

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Lower Urinary Tract Hypersensitivity Questionnaire – page 2

Name_____ dob _____

11. Do your symptoms vary with your menstrual cycle? Yes No
If yes, How? _____

12. Have you ever been treated by
    Antibiotics? Yes No
    Antispasmodics? Yes No
    Urethral dilation? Yes No
    Bladder dilation? Yes No
    Or other treatments? Yes No

13. If yes, how did you respond to treatment? _____

14. Are your symptoms made worse by:
    Alcohol? Yes No
    Carbonation? Yes No
    Coffee? Yes No
    Citrus? Yes No
    Physical activity? Yes No
    Spicy foods? Yes No
    Standing for prolonged periods? Yes No
    Stress? Yes No

15. Are your symptoms relieved by:
    Antibiotics? Yes No
    Anti-inflammatories (such as aspirin,motrin)? Yes No
    Antispasmodics? Yes No
    Drinking water? Yes No
    Lying down? Yes No
    Onset of menses? Yes No
    Prescription pain pills? Yes No
    Or does nothing help? Yes No

16. How were your symptoms affected by pregnancy and breastfeeeding? Better – worse – unchanged

17. What is your normal daily fluid intake of coffee _____ tea _____ beverages _____
    fruit juices _____ alcohol _____ water _____ milk _____ carbonated drinks _____

18. What do you fear most about your problem? _____
_____