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Urinary Incontinence Questionnaire

Name _____ Date _____

Age _____ Height _____ Weight _____ No. Vaginal Births _____ No. Cesarean Sections _____

1. In general, how would you rate your bladder control:

	Good _____
	Fair _____
	Poor _____
	Terrible _____

2. How often do you urinate during the daytime? Approximately every _____ hrs

3. How much fluid do you usually drink: (Please estimate in oz.)

During the day?	Ounces _____
After dinner?	Ounces _____

4. Do you ever accidentally lose your bladder control and wet your clothing? Yes _____

If yes, how often does this occur? (Check one)

	Rarely _____
	Occasionally _____
	Weekly _____
	Daily _____

If yes, estimate the volume of accidental urine loss: (Check one)

Clothing is slightly damp?	_____
Clothing is wet?	_____
Clothing is soaking wet?	_____

5. Do you wear a pad for protection against urinary accidents? Yes _____

If yes, how often do you wear a pad? (Check one)

All day	_____
Only when away from the house	_____
Only with exercise or strenuous activities	_____
Only with a cold and cough	_____

If yes, approximately how many pads will you usually use each day? Number of Pads _____

6. Do you accidentally urinate during any of the following: (Check each)

Coughing	_____
Sneezing	_____
Jumping	_____
Laughing	_____
Exercising	_____
Walking	_____

7. Do you usually have to hurry to the toilet, or can you take your time?

	Hurry _____
	Take Time _____

8. If you have a strong urge to urinate, can you suppress the feeling?

	Usually _____
	Occasionally _____
	Rarely _____

9. Do you ever have the urge to urinate and accidentally lose urine before reaching the toilet? Yes _____
10. When you get the urge to urinate, is it usually painful? Yes _____
If Yes, is the pain relieved after urinating? Yes _____
11. How many times at night do you usually get up to urinate? Number _____
12. Upon awakening in the morning, do you usually hurry to the bathroom? Yes _____
If yes, do you ever accidentally leak before reaching the toilet? Yes _____
13. Are you ever unaware that you have urinated until you feel wet? Yes _____
14. Do you feel you are wet most of the time? Yes _____
15. Do you feel that you empty your bladder completely? No _____
16. While you are urinating, are you able to stop the flow? No _____
17. Do you notice any dribbling of urine when you stand up after urinating? Yes _____
18. Have you ever been treated by dilation of the urethra? Yes _____
19. Have you had a urinary infection during this past year? Yes _____
If Yes, more than twice? Yes _____
20. Do you have symptoms of infection after intercourse? Yes _____
21. Is your urine ever bloody? Yes _____
22. Are there certain activities (sports, dancing, etc.), which you have stopped? Yes _____
because of your incontinence?
If yes, please describe: _____

Pelvic Floor Support:

1. Do you have any problem with your bowel movements? Yes _____
If Yes, do you ever splint (support) your vagina with your fingers? Yes _____
2. Do you ever accidentally soil yourself with stool? Yes _____
3. Do you or your partner feel that your vagina is “too loose” for enjoyable intercourse? Yes _____
4. Do you ever have a feeling that your pelvic organs or tissues are protruding from your vaginal opening? Yes _____
If Yes, under what circumstances? _____
5. Do you perform Kegel pelvic floor muscle exercises? Yes _____

Please list all your current medications (including non-prescription):
