

PATIENT QUESTIONNAIRE FOR URINARY INCONTINENCE

Take a moment to fill out the questionnaire below. Please print this form when you are finished and we will be happy to review your answers with you at a scheduled appointment.

Name: Date:

Do You:

1. Use the bathroom frequently (More than every 1 to 2 hours)? Y N
2. Have sudden strong urges to urinate that you cannot suppress? Y N
3. Wake up to urinate one or more times per night? Y N
4. Know the location of every restroom in the shopping mall or stores? Y N
5. Plan your activities around bathroom facilities? Y N
6. Usually empty your bladder before leaving the house? Y N
7. Wear a pad to protect yourself "just in case" of a wetting accident? Y N
8. Lose urine during certain physical activities or exercising? Y N
9. Have accidental leaking of urine when sneezing, coughing, or laughing? Y N
10. Have you given up activities in life you enjoy because of poor bladder control? Y N
11. Experience accidental leaking of stool or gas? Y N
12. Have difficulty evacuating your stool, especially if constipated? Y N
13. Have a feeling that your uterus or vaginal lining has "fallen"? Y N
14. Have pelvic pressure after being physically active? Y N
15. Feel your vagina is too loose for enjoyable intercourse? Y N