

Bladder Health Questionnaire

1. How often do you urinate during the day? _____
2. How often do you get up at night to urinate? _____
3. Is the amount of urine you usually pass... Large Average Small
4. Do you usually have a strong sense of urgency to urinate? No Yes
- Do you have to hurry to empty your bladder when full? No Yes
 - Are there times when you don't make it to the bathroom and leak urine? No Yes
 - Can you overcome the sensation of the urgency to urinate? No Yes
 - Does the sight, sound, or feel of running water cause you to lose urine? No Yes
 - Do you ever lose urine when lying down? No Yes
 - Do you experience any sensations before losing urine? No Yes
 - When urinating, can you usually stop your stream? No Yes
 - Do you ever accidentally wet the bed while sleeping? No Yes
5. Do you have difficulty starting your urine stream? No Yes
- Do you feel that you have completely emptied your bladder after urinating? No Yes
 - Do you dribble urine after voiding? No Yes
6. Were you ever catheterized because you were unable to void? No Yes
- Have you ever had your urethra dilated or stretched? No Yes
 - Do you ever pass blood in your urine? No Yes
 - Have you ever passed sand, gravel, or stones? No Yes
 - Do you have pain during urination? No Yes
7. Have you been treated for three or more urinary infections? No Yes
- Have you been treated for an infection within six months? No Yes

8. Do you lose urine while coughing, sneezing, laughing, lifting, jumping, or running?

No Yes

- Do you find it necessary to use some type of protection?

No Yes

9. Did your urinary difficulty begin:

- During a pregnancy?

No Yes

- Following a delivery?

No Yes

- Following an abdominal or vaginal operation?

No Yes

- After menopause?

No Yes

- Other? Please explain: _____

10. List all medications you have taken in the past six months. Circle those medications you are presently taking.

