Urinary Incontinence Intake Questionnaire

Name:_____
DOB_____ Age_____
Referring Physician_____
Date_____

1. **When did your urinary loss start**?
   Less than 6 months
   More than 6 months
   More than 1 year
   More than 2 years
   More than 3 years
   More than 5 years

2. **Was it associated with a specific incident?**
   Childbirth
   Surgery
   Menopause
   Medical Illness

3. **How has the incontinence changed over time?**
   Stayed the same
   Improved
   Worsened

4. **When do you lose urine?**
   Daytime
   Nighttime
   Both day and night

5. **How many times per day do you lose urine?**
   Once
   Twice
   Three
   More than three
   Constantly

6. **How much urine do you lose during an accident?**
   Teaspoonful
   Tablespoonful
   ½ Cup
   More than 1 cup full

7. **What type of protection do you use to day dry?**
   None
   Panty Liner

Mini-Pad
Maxi-Pad
Diaper

8. **How often do you change the protective device on an average day?**
   Zero
   Once
   Two to Three times
   Three to four times
   Five to six times
   More than six times

9. **What causes you to lose urine?**
   Cough
   Laugh
   Sneeze
   Putting the key in the door
   Hand-washing
   Physical activity

10. **Do you have an urge or warning before the bladder accident?**
    Yes
    No

11. **Do you lose urine when sitting still?**
    Yes
    No

12. **Do you lose urine on the way to the bathroom?**
    Yes
    No

13. **How many times do you urinate during the day?**
    Once
    Two to three
    Three to four
    Four to five
    Five to six
    More than six

14. **How many times do you wake up to urinate at night?**
    Zero
    Once
    Two to three
    More than three

15. How many glasses of fluid do you drink per day?

One glass
Two to three glasses
Three to five glasses
Five to seven glasses
Seven to nine glasses
More than nine glasses

16. Do you feel you empty your bladder completely?

Yes
No

17. If you have had previous urologic surgery, please indicate dates:

_____
_____
_____

18. If you have had gynecological surgery, please indicate dates:

_____
_____
_____

19. Have you ever seen blood in your urine?

Yes
No

20. Do you have a history of urinary tract infections?

Less than 6 months
More than 6 months

21. How many vaginal deliveries have you had?

Zero
One
Two
More _____

22. Have you had any type of cancer?

Yes What type_____
No

23. Have you been diagnosed with any of the following conditions?

Neurological problems
Multiple Sclerosis
Parkinson's disease
Stroke
Disc Surgery
Back Problems
Spinal Injury

24. Are you a diabetic?

Yes Do you take insulin?

No

25. Do you have hypertension?

Yes Do you take a diuretic?

No

26. Please check any of the following conditions that apply to you:

Heart disease

Lung disease

Stomach Problems

Liver Problems

Bowel difficulty

27. Please list all medications you take, including over-the-counter:

_____

_____

_____

_____

28. Please list medications you have taken in the past to treat the bladder condition: _____

_____

29. Did the previously listed medications help your bladder?

Yes

No

30. Please list the names of doctors you would like to receive a report of your urologic evaluation._____

_____

31. Please list anything else that you feel may be important about your bladder condition:_____

_____

_____