

# 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.

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