



# BLADDER HEALTH FOLLOW-UP

Our goal is to provide you the best possible care, which is why we're sending you this very brief questionnaire. It's a simple, convenient way for you to follow up on your last appointment, make sure that you're comfortable with your treatment path and find out if you have any questions for your doctor. Please answer the questions below and email or fax them back to us.

Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## YOUR TREATMENT:

If your doctor prescribed treatment to you after your last visit, please list the treatment here and answer the following questions.

Treatment: \_\_\_\_\_

**1. Did you start the treatment? Yes/No**

If no, why not? \_\_\_\_\_

**2. What date did you start treatment? \_\_\_\_\_**

**3. Have you been consistent with your treatment plan? Yes/No**

If no, why not? \_\_\_\_\_

**4. Have you experienced any side effects with the treatment you have started on? Yes/No**

If yes, please describe: \_\_\_\_\_

**5. Have you experienced any difficulty following the treatment your doctor started you on? Yes/No**

If yes, please describe: \_\_\_\_\_

## THE STATE OF YOUR CONDITION:

**1. Has your condition improved or worsened since you last saw your doctor?  
Improved/Worsened**

Please describe any improvements or worsening of symptoms: \_\_\_\_\_

**2. Have you changed anything about your diet or exercise routine since you last saw your doctor? Yes/No**

If yes, please describe: \_\_\_\_\_

**3. Have you tried anything else on your own to treat your bladder symptoms since you last saw your doctor? Yes/No**

If yes, please describe: \_\_\_\_\_

## QUESTIONS:

*If yes, you have any questions for your doctor, please list them here:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# BLADDER HEALTH FOLLOW-UP

*Continued from previous page*

## **PRESCRIBED TREATMENT**

**15. Have you ever been prescribed a treatment for your bladder leaks? Yes/No**  
**(If no, skip the remaining questions)**

**16. Which of the following treatments have you tried (check all that apply)?**

- ☐ Changes in diet or exercise
- ☐ Physical therapy
- ☐ Sacral Nerve Modulation (including InterStim therapy)
- ☐ NURO
- ☐ Surgery
- ☐ Catheters
- ☐ Medications (indicate below)

Medication name

How effective was it?

Side effects experienced

---



---



---



---



---



---



---



---



---

- ☐ Other (indicate below)

---

**17. Are you on any prescribed treatment now? Yes / No**

**18. If you are using a prescribed treatment now, what is it?**

---

**19. Are you happy with the prescribed treatment you are on? Yes/No** 

---

**20. If you are not happy with your current treatment, or if you stopped a treatment previously prescribed, why?**

- ☐ Did not help
- ☐ Too expensive
- ☐ Unwanted side effects (explain below)

---

- ☐ Other (explain below)

---