

BLADDER HEALTH QUESTIONNAIRE

We want you to get the most out of your visit with your doctor. By answering a few questions below before your appointment, you and your doctor can work together to discuss your symptoms and find the appropriate treatment option.

Name: _____

Date Of Birth: _____

Today's Date: _____

SYMPTOMS

1. Do you have any bladder health incontinence symptoms (frequent urination, involuntary loss of urine, etc)? Yes/No

If so, list them here: _____

2. How often do you urinate during the day? _____

3. How often do you get up at night to empty your bladder? _____

4. Do you leak urine when you laugh, cough, sneeze, lift something heavy, jump or work out? Yes/No

5. Do you find it necessary to use some type of leak protection? Yes/No

6. Do you usually have a strong sense of urgency to urinate? Yes/No

7. Do you ever leak urine before making it to the bathroom? Yes/No

8. Does the sight, sound or feel of running water cause you to lose urine? Yes/No

9. When urinating, can you usually stop your stream? Yes/No

10. Do you ever wear pads/diapers due to leaking? Yes/No

11. Do you feel like you are able to completely empty your bladder when you urinate? Yes/No

12. Do you feel pressure or physical discomfort in your pelvic region? Yes/No

13. On a scale from 1 - 10, with 1 being least bothersome and 10 being most bothersome, how would you characterize your symptoms?

Circle one: 1 2 3 4 5 6 7 8 9 10

14. Do your bladder leaks or frequent urination episodes make you feel any of the following

(Check all
that apply)

- ☐ Annoyed
- ☐ Frustrated
- ☐ Ashamed
- ☐ Embarrassed
- ☐ Fearful of accidents

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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)
