PATIENT NAME_____

DATE_____

INCONTINENCE QUESTIONNAIRE

Please answer the questions below about your symptoms.

How long have you had a leakage problem?	_____
How often do you urinate?	About every___hour(s)
How many times do you get up at night to urinate?	About___times
Do you wet yourself when you cough, sneeze, stand up?	Yes No
Do you have to run to the bathroom to avoid wetting yourself?	Yes No
Do any fluids or foods make the leakage worse? (List under other comments)	Yes No
Do you use pads to absorb urine leakage?	Yes No
If so, how many do you use per day?	_____
Do you have burning pain when you urinate?	Yes No
Do you have pain in your lower abdomen or back?	Yes No
Have you recently seen blood in your urine?	Yes No
Does your urine stream dribble and have no force?	Yes No
Do you have any problems with bowel movements?	Yes No
Has your condition gotten worse since it started?	Yes No
Have you been evaluated or treated before?	Yes No
Do you smoke?	Yes No
Are you sexually active?	Yes No

Other comments: _____

_____

MEDICATIONS:

Check any medications you have taken within the past 3 months.

___Diuretics (water pills)
___High blood pressure medication
___Sleeping pills/tranquillizers
___Hormones
___Antihistamines, decongestants, cold meds
___Herbal tharapies

MEDICAL HISTORY:

Check any below that apply to you.

___Illness or injury to back or pelvis
___Surgery to the back, pelvis, or bladder
___Stroke or brain damage
___Nerve disorders (such as Parkinson's)
___Radiation to the pelvis
___Glaucoma
___Vaginal delivery of children ___times
___Urinary tract infection within past 3 mo