

BLADDER SYMPTOM QUESTIONNAIRE

Patient Name: _____ Patient Date of Birth: _____ Doctor Name:

Which symptoms best describe you? Check all that apply.

- Frequent urination--day, night, or both
- Sudden or strong urge to urinate
- Leakage with little or no warning-sometimes unable to make it to the bathroom in time
- Unable to completely empty bladder-feels like there is more even after going to the bathroom
- Accidental leakage with physical activity-exercising, sneezing, or coughing
- Bladder or pelvic pain
- Problems with bowel function (if checked, please select symptom below)
 - Accidental loss or leakage of stool
 - Constipation
 - Other
- No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried? _____

On a scale of 1 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

1 2 3 4 5 6 7 8 9 10
 No Relief Complete Relief

Are you still taking any of these medications?

Yes No

If no, why have you stopped taking them?

- Did not work as well as expected
- Interaction with other medications
- Side effects
- Expense
- Other

If Side effects or Other checked, please explain:

Behavior modifications tried? (ex: reduced fluid intake, caffeine reduction, kegel exercises, physical therapy or life style changes.)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number.

0 1 2 3 4 5 6 7 8 9 10
 Not Frustrated Extremely Frustrated

Are you interested in learning more about additional treatment alternatives to bladder medications?

Yes No