***BLADDER HEALTH HISTORY***

*ALL INFORMATION IS STRICTLY CONFIDENTIAL*

1. Do you ever leak urine during a cough, sneeze, laugh or other physical activity? [ ]  No [ ]  Yes
2. What other types of activities cause this to occur? [ ]  No [ ]  Yes
3. Immediately after finishing urinating, do you feel the sensation of needing to urinate again? [ ]  No [ ]  Yes
4. Do you sometimes dribble just prior to or just after urination? [ ]  No [ ]  Yes
5. Do you leak spontaneously without warning? [ ]  No [ ]  Yes
6. Do you leak if you have a sudden urge? [ ]  No [ ]  Yes
7. Do you use protective pads or diapers? [ ]  No [ ]  Yes
8. How many per day? [ ]  None [ ]  1-3 [ ]  4+ Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Have you tried Kegel exercises, biofeedback or another non-surgical means of controlling incontinence? [ ]  No [ ]  Yes
10. Do you have frequent urinary tract infections? [ ]  No [ ]  Yes
11. Have you ever had blood in your urine? [ ]  No [ ]  Yes
12. Do you have pain when you urinate? [ ]  No [ ]  Yes
13. Does your urinary problem interfere with your daily activities? [ ]  No [ ]  Yes
14. Does your urinary problem interfere with your sexual activities? [ ]  No [ ]  Yes
15. Do you get up at night to urinate? How many times? [ ]  None [ ]  1-3 [ ]  4+
16. Have you ever had a gynecological or urological surgical procedure such as a bladder neck suspension or hysterectomy? [ ]  No [ ]  Yes
17. 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 or 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

**Patient’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_