

Bladder Health History

Name: _____

DOB: _____

Referring MD _____

Date/Time completed: _____

1. When did your leaking start?

- Less than 6 months
- More than 6 months
- More than 1 year
- More than 2 years
- More than 3 years
- More than 5 years

2. How has the incontinence changed over time?

- stayed the same
- improved
- worsened

3. When do you leak?

- Day time
- Night time
- Both day and night

4. How many times per day do you leak?

- Once
- Twice
- Three
- Greater than three
- Constantly

5. How much do you leak during an accident?

- teaspoonful
- tablespoonful
- 1/2 cup
- more than 1 cupful

6. What type of protection do you use to stay dry?

- None
- Panty liner
- Mini-pad
- Maxi-pad
- diaper
- Other:

7. Was it associated with a specific event?

- Child birth
- Surgery
- Menopause
- Medical illness
- Other:

8. How often do you change the protective device on an average day?

- Zero
- Once
- Two to three times
- Three to four times
- Five to six times
- More than six times

9. What causes you to leak?

- (check all that apply)
- Cough Laugh Sneeze
 - Handwashing Physical activity
 - Just getting to the toilet
 - Other

10. Do you have an urge or warning before the accident?

- Yes
- No

11. Do you leak when sitting still?

- Yes
- No

12. Do you feel you empty your bladder/bowel completely?

- Yes
- No

13. Have you ever seen blood in your urine?
Yes No

14. Do you have a history of urinary tract infection?
Less than 6 months
More than 6 months

14. b. If yes, please state how often in the
past year:

15. Please list any medications you have taken
in the past or are taking now to treat your
bladder condition:

16. Please list the names and addresses of the
doctors that you would like to receive a report
of your urologic evaluation

Bowel Symptoms

Do you: (please circle all that apply)

Strain to have a bowel movement
Include fiber in your diet
Take laxative / enema regularly
Have pain with bowel movements
Have a very strong urge to move your bowels
Leak / stain feces
Have diarrhea often
Leak gas by accident
Have hemorrhoids

17. How often do you move your bowels?
_____per day/week

18. Most common stool consistency
liquid
soft
firm
pellets
other

19. Please use this space to list anything else
that you feel may be important about your
bladder, bowel or painful condition.