

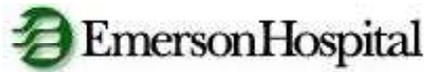
**CENTER FOR REHABILITATIVE
AND SPORT THERAPIES**

BLADDER HEALTH INTAKE QUESTIONNAIRE

PATIENT ID

1. When did your urinary loss start: <input type="checkbox"/> less than 6 mos <input type="checkbox"/> more than 6 mos <input type="checkbox"/> more than 1 yr <input type="checkbox"/> more than 2 years <input type="checkbox"/> more than 3 years <input type="checkbox"/> more than 5 years
2. Was it associated with a specific event? <input type="checkbox"/> childbirth <input type="checkbox"/> surgery <input type="checkbox"/> menopause <input type="checkbox"/> medical illness <input type="checkbox"/> other _____
3. How has the incontinence changed over time? <input type="checkbox"/> stayed the same <input type="checkbox"/> improved <input type="checkbox"/> worsened
4. When do you lose urine? <input type="checkbox"/> day time <input type="checkbox"/> night time <input type="checkbox"/> both day and night
5. How many times per day do you lose urine: <input type="checkbox"/> once <input type="checkbox"/> twice <input type="checkbox"/> three <input type="checkbox"/> greater than three <input type="checkbox"/> constantly
6. How much urine do you lose during an accident? <input type="checkbox"/> teaspoonful <input type="checkbox"/> tablespoonful <input type="checkbox"/> ½ cup <input type="checkbox"/> more than 1 cup
7. What type of protection do you use to stay dry? <input type="checkbox"/> nothing <input type="checkbox"/> panty liner <input type="checkbox"/> mini-pad <input type="checkbox"/> maxi-pad <input type="checkbox"/> diaper <input type="checkbox"/> other _____
8. How often do you change the protective device on an average day? <input type="checkbox"/> 0 times <input type="checkbox"/> 2-3 times <input type="checkbox"/> 3-4 times <input type="checkbox"/> 5-6 times
9. What causes you to lose urine? (check all that apply) <input type="checkbox"/> cough <input type="checkbox"/> laugh <input type="checkbox"/> sneeze <input type="checkbox"/> handwashing <input type="checkbox"/> physical activity <input type="checkbox"/> just getting to the toilet <input type="checkbox"/> other _____
10. Do you have an urge or warning before the bladder accident? <input type="checkbox"/> yes <input type="checkbox"/> no; Do you lose urine when sitting still? <input type="checkbox"/> yes <input type="checkbox"/> no
11. Do you feel you empty your bladder completely? <input type="checkbox"/> yes <input type="checkbox"/> no
12. Have you ever seen blood in your urine? <input type="checkbox"/> yes <input type="checkbox"/> no
13. Do you have a history of urinary tract infections? <input type="checkbox"/> yes <input type="checkbox"/> no; If yes, please state how often in the past year.
14. Please list any medications you have taken in the past or are taking now to treat your bladder condition:





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BOWEL SYMPTOMS

1. Do you: (please check all that apply) strain to have a bowel movement include fiber in your diet take a laxative/enema regularly
 have pain with bowel movements have a very strong urge to move your bowels leak/stain faces have diarrhea often
 leak gas by accident

2. How often do you move your bowels? _____ per day/week

3. Most common stool consistency. liquid soft firm

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

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

