EmersonHospital

CENTER FOR REHABILITATIVE AND SPORT THERAPIES

PATIENT ID

BLADDER HEALTH INTAKE QUESTIONNAIRE

1. When did your urinary loss start: ❑ less than 6 mos ❑ more than 6 mos ❑ more than 1 yr ❑ more than 2 years ❑ more than 3 years ❑ more than 5 years
2. Was it associated with a specific event? ❑ childbirth ❑ surgery ❑ menopause ❑ medical illness ❑ other _____
3. How has the incontinence changed over time? ❑ stayed the same ❑ improved ❑ worsened
4. When do you lose urine? ❑ day time ❑ night time ❑ both day and night
5. How many times per day do you lose urine: ❑ once ❑ twice ❑ three ❑ greater than three ❑ constantly
6. How much urine do you lose during an accident? ❑ teaspoonful ❑ tablespoonful ❑ ½ cup ❑ more than 1 cup
7. What type of protection do you use to stay dry? ❑ nothing ❑ panty liner ❑ mini−pad ❑ maxi−pad ❑ diaper ❑ other _____
8. How often do you change the protective device on an average day? ❑ 0 times ❑ 2−3 times ❑ 3−4 times ❑ 5−6 times
9. What causes you to lose urine? (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 bladder accident? ❑ yes ❑ no; Do you lose urine when sitting still? ❑ yes ❑ no
11. Do you feel you empty your bladder completely? ❑ yes ❑ no
12. Have you ever seen blood in your urine? ❑ yes ❑ no
13. Do you have a history of urinary tract infections? ❑ yes ❑ 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.

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