

Bladder Health Questionnaire

Please bring this form with you on the day of your appointment.

Name: _____

Date: _____

Physician: _____

Allergies: _____

How often do you urinate during the day/evening? _____

How often do you get up at night to urinate? _____

When did your bladder problems begin? _____

Do you usually have a strong sense of urgency to urinate? Yes No

Do you experience pain when your bladder is full? Yes No

Can you postpone emptying your bladder easily? Yes No

Do you lose urine when: you are lying down or asleep? Yes No

you sneeze, cough, jump, run, laugh? Yes No

you get up from a sitting position? Yes No

you hear, see or feel running water? Yes No

you can't get to bathroom on time? Yes No

Do you wear protection for urinary leakage? Yes No

If yes, what do you use? _____

How many days? _____

Do you have difficulty starting your urine stream? Yes No

How do you start your urine stream? ___easy ___push/strain
___wait less than 1 minute ___wait more than 1 minute

Do you have pain when emptying your bladder? Yes No

When urinating, can you stop your stream? Yes No

Do you feel you have completely emptied your bladder? Yes No

Do you notice dribbling of urine after emptying your bladder? Yes No

Did you ever have a tube placed in your bladder because you
were unable to empty your bladder? Yes No

Have you ever had your urethra dilated or stretched? Yes No

Have you ever-passed blood in your urine? Yes No