WOMEN'S HEALTH and Menopause Center

BLADDER HEALTH QUESTIONNAIRE

Name:

Date:

1.	How often do you urinate during the day?			
2.	How often do you get up at night to urinate?			
3.	Is the amount of urine you usually pass...	Large	Average	Small
4.	Do you usually have a strong sense of urgency to urinate?		Yes	No
	Do you have to hurry to empty your bladder when full?		Yes	No
	Are there times when you don't make it to the bathroom and leak urine?		Yes	No
	Can you overcome the sensation of the urgency to urinate?		Yes	No
	Does the sight, sound, or feel of running water cause you to lose urine?		Yes	No
	Do you ever lose urine when lying down?		Yes	No
	Do you ever experience any sensations before losing urine?		Yes	No
	When urinating, can you usually stop your stream?		Yes	No
	Do you ever accidentally wet the bed while sleeping?		Yes	No
5.	Do you have difficulty starting your urine stream?		Yes	No
	Do you feel that you have completely emptied your bladder after urinating?		Yes	No
	Do you dribble urine after voiding?		Yes	No
6.	Were you ever catheterized because you were unable to void?		Yes	No
	Have you ever had your urethra dilated or stretched?		Yes	No
	Do you ever pass blood in your urine?		Yes	No
	Have you ever passed sand, gravel, or stones?		Yes	No
	Do you have pain during urination?		Yes	No
7.	Have you been treated for three or more urinary infections?		Yes	No
	Have you been treated for an infection within six months?		Yes	No
8.	Do you lose urine while coughing, sneezing, laughing, lifting, jumping, or running?		Yes	No
	Do you find it necessary to use some type of protection?		Yes	No
9.	Did your urinary difficulty begin:			
	During a pregnancy?		Yes	No
	Following a delivery?		Yes	No
	Following an abnormal or vaginal operation?		Yes	No
	After menopause?		Yes	No
	Other? Please explain:			

10. List all medications you have taken in the past six months. Circle those medications you are presently taking.

Patient's Signature

PHYSICIAN'S SIGNATURE

PRINT RESET