Bladder Health Questionnaire

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

Other? Please explain: ____

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

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Rena Azar, MD