

DUNWOODY OBSTETRICS & GYNECOLOGY, PC

Bladder Health Questionnaire

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 urethra 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.

