Incontinence Symptom Questionnaire

Collaborative to Support Urinary Incontinence and Women's Health
CSUIWH
www.StressUI.org

Last Name _____ First Name _____ Middle Initial _____ Telephone _____

Address _____ City _____ State _____ ZIP _____ E-mail Address _____

Instructions: Please answer the following questions about your urine (water) leakage. When you return the completed form, we will examine the information you've recorded and discuss it with you.

1. How long have you leaked urine? _____

2. Since you began leaking urine, has the amount you leak each time:
❑ Increased ❑ Decreased ❑ Stayed the same

3. Has the number of times you have leaked urine each day, week, or month:
❑ Increased ❑ Decreased ❑ Stayed the same

4. Please place a check next to the word that best describes how often each of the following activities causes you to leak urine.

	Never	Sometimes	Often
a) Exercising, including running and participating in other high-impact sports	❑	❑	❑
b) Sneezing	❑	❑	❑
c) Coughing	❑	❑	❑
d) Laughing	❑	❑	❑
e) Lifting	❑	❑	❑
f) Changing position from sitting or standing up	❑	❑	❑
g) Bending down	❑	❑	❑
h) Reaching	❑	❑	❑
i) Walking or rushing to the toilet	❑	❑	❑
j) Seeing or hearing running water	❑	❑	❑
k) Washing hands	❑	❑	❑
l) Feeling nervous or stressed	❑	❑	❑
m) Being out in cold weather	❑	❑	❑
n) Unlocking the front door	❑	❑	❑

5. Do you have strong urinary urges that you cannot always control?
❑ Yes ❑ No

6. Once your bladder feels full, how long can you hold your urine?
❑ As long as I want
❑ Less than a minute
❑ A few minutes
❑ Cannot tell when bladder is full

7. How often do you leak urine?
❑ Once a week at most ❑ 2 or 3 times a week
❑ About once a day ❑ Several times a day
❑ Continuously

8. When does the leakage occur?
❑ Mainly during the day ❑ Mainly at night
❑ Both day and night

9. Do you ever find yourself wet or damp without realizing that you've leaked urine?
❑ Never ❑ Sometimes ❑ Always

10. Do you wake up in the night to urinate?
❑ Never or rarely ❑ 2-3 times per week
❑ Almost every night ❑ 1 time per night
❑ 2 times per night ❑ 3 or more times per night

11. Please indicate how much urine you usually leak.
❑ A small amount (leaves you slightly damp)
❑ A moderate amount (1 or 2 tablespoons)
❑ A large amount (more than 2 tablespoons)

12. How much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 5 (a great deal).

0 1 2 3 4 5

13. If you avoid any of the following activities because you might leak urine, please check them below.
❑ Exercising ❑ Playing sports
❑ Dancing ❑ Traveling
❑ Dating ❑ Shopping
❑ Working outside the home ❑ Having sex

14. Has urine leakage stopped you from doing any of the above activities during the past 5-10 years? If so, please list those activities below.

_____

_____

_____

_____

Last Name First Name Middle Initial

15. Please check anything listed below that has occurred when you urinate.

- ❑ Difficulty in getting urine started
- ❑ Very slow stream or dribbling
- ❑ Discomfort, burning, or pain
- ❑ Blood in the urine
- ❑ Feeling that your bladder did not empty completely
- ❑ Loss of urine in sudden, large amounts
- ❑ Stopping and starting urine stream
- ❑ Urinate, stand up, urinate again to empty your bladder
- ❑ Lose urine as you walk away from the toilet

16. Did you wet the bed as a child?

❑ Yes ❑ No

If so, until what age? _____ How often? _____

17. If you have been treated for bladder leakage, urgency, or frequency before, please check all of the treatments that you have received in the past.

- ❑ Acupuncture
- ❑ Medications
- ❑ Electrical stimulation
- ❑ Biofeedback
- ❑ Surgery
- ❑ Pelvic muscle exercises
- ❑ Bladder training
- ❑ Collagen injections
- ❑ Urethral inserts/incontinence pessaries
- ❑ Other treatments? Please list them below.

_____

_____

18. In the chart below, please place a check next to the medications you have used or are currently using to treat incontinence, and indicate whether or not they have improved your condition.

Medication	**Used (√)**	**Was the medication helpful?**	
Detrol® (tolterodine)	❑	❑ Yes	❑ No
Ditropan® (oxybutynin)	❑	❑ Yes	❑ No
Levsin®, Levsinex®, Cystospaz® (hyoscyamine)	❑	❑ Yes	❑ No
Tofranil® (imipramine)	❑	❑ Yes	❑ No
Pro-Banthine® (propantheline)	❑	❑ Yes	❑ No
Urispas® (flavoxate)	❑	❑ Yes	❑ No
Ornade® (chlorpheniramine and phenylpropanolamine)	❑	❑ Yes	❑ No
Sudafed® (pseudoephedrine)	❑	❑ Yes	❑ No
DDAVP® (desmopressin)	❑	❑ Yes	❑ No
Oxytol Patch	❑	❑ Yes	❑ No
Other(s)	❑	❑ Yes	❑ No

19. Have you ever had to use a catheter to drain your bladder?

❑ Yes ❑ No

20. Please check all of the "self-help" techniques you have used to deal with urine leakage.

- ❑ Wear panty liners
- ❑ Wear sanitary napkins or incontinence pads
- ❑ Wear adult pads or briefs designed for urine control
- ❑ Wear other protective underclothes
- ❑ Put toilet paper/paper towels inside briefs
- ❑ Drink less fluids
- ❑ Go to the toilet often
- ❑ Stay near a bathroom
- ❑ Use a bedside commode or bedpan

21. Have you used any other self-help techniques? Please list them below.

_____

_____

_____

22. How often do you have a bowel movement?

- ❑ Once a day
- ❑ More than once a day
- ❑ 2-3 times a week
- ❑ Less than once a week

23. If you have had any of the problems listed below, please check them.

- ❑ Straining on more than 1 out of 4 bowel movements
- ❑ Using enemas or laxatives (not fiber or bulk) to relieve constipation more than once a month
- ❑ Diarrhea (how often? _____)
- ❑ Bloody stool
- ❑ Change in the pattern of your bowel movements over the past year
- ❑ Uncontrolled loss of stool

24. a) Are you sexually active now?

❑ Yes ❑ No

b) If so, do you have trouble/pain urinating after intercourse?

❑ Yes ❑ No

c) Do you have discomfort/pain with intercourse?

❑ Yes ❑ No

25. What changes would you like to see in your symptoms as a result of your treatment here?

_____

_____

_____

Thank you for completing this form.

Reviewed by Clinician: _____ Date: _____

Adapted from the following sources:

American Geriatrics Society. Urinary incontinence in older adults: management in primary practice. American Geriatrics Society Web site. Available at: http://www.americangeriatrics.org/education/urinary_incontinence.shtml. Accessed July 3, 2003.

Nelson E, for the Women's Continence Clinic (Southern Illinois University, Department of Obstetrics and Gynecology). Incontinence symptom questionnaire. Southern Illinois University School of Medicine Web site. Available at: http://www.siumed.edu/ob/downloads/incontinence_questions.pdf. Accessed July 3, 2003.

Newman DK. *Managing and Treating Urinary Incontinence.* Baltimore: Health Professions Press; 2002.

Daily Bladder Diary Instructions

www.StressUI.org

By filling out the Bladder Diary, you'll be taking another step toward improving your health. When you return the completed form, we'll examine the information you recorded and discuss our treatment recommendations with you as soon as possible.

As you read the instructions, please keep in mind that the more accurate you are in recording the information, the better we'll be able to identify the problem and assist you in addressing it.

Instructions:

Column 1

As you'll see, this Daily Bladder Diary is divided into 2-hour time slots.

Column 2

Please place a check in Column 2 (in the correct time slot) each time you urinate in the toilet.

Column 3

Every time you leak urine, please indicate in Column 3 whether you have leaked a small (S), medium (M), or large (L) amount. If the amount of urine you leak leaves you slightly damp, mark an "S" in the correct time slot. If you have leaked about a tablespoon or 2 of urine, please place an "M" in that time slot. If you have experienced a loss of urine greater than about 2 tablespoons, please place an "L" in that time slot.

Column 4

Please write down (in the correct time slot) what you were doing when you leaked urine, such as sneezing, lifting, coughing, laughing, rushing to the bathroom, etc.

Column 5

Please place a check in Column 5 (in the correct time slot) if you felt a need or urge to urinate at the same time you were leaking urine.

Column 6

Every time you drink liquid, please indicate what you drank, such as coffee, water, orange juice, etc. (in the correct time slot), and estimate the amount you drank, such as one cup (8 ounces), 1/2 cup, etc.

Adapted from the following sources:

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Evidence-Based Clinical Practice Guideline: Continence for Women.* Herndon, Va.: AWHONN; 2000.
Newman DK. *Managing and Treating Urinary Incontinence.* Baltimore: Health Professions Press; 2002.

Daily Bladder Diary

Last Name _____ First Name _____ Middle Initial _____ Telephone _____

Address _____ City _____ State _____ ZIP _____ E-mail Address _____

www.StressUI.org

Please complete one of these forms each day, for _____ days, as recommended by your clinician. Date: _____

1	2	3	4	5	6
Time Interval	**Voided in Toilet**	**Urine Leakage (S, M, L)**	**Activity at Time of Leakage**	**Urge Present**	**Liquid Intake (Type, Amount)**
6:00 to 8:00 AM					
8:00 to 10:00 AM					
10:00 to NOON					
NOON to 2:00 PM					
2:00 to 4:00 PM					
4:00 to 6:00 PM					
6:00 to 8:00 PM					
8:00 to 10:00 PM					
10:00 to MIDNIGHT					
MIDNIGHT to 2:00 AM					
2:00 to 4:00 AM					
4:00 to 6:00 AM					

If you used pads or other protective garments this week, please indicate below what type of pad you used and how many you used per day.

Type of pad used: _____ Number of pads used per day: _____

Clinician Signature: _____ Date: _____

Adapted from the following sources:

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Evidence-Based Clinical Practice Guideline: Continence for Women.* Herndon, Va.: AWHONN; 2000.

Newman DK. *Managing and Treating Urinary Incontinence.* Baltimore: Health Professions Press; 2002.