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 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?  
   - 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.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________