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? ❑ 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: _____

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

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