Women’s Continenence and Pelvic Health Center
The purpose of this questionnaire is to help us determine the best possible treatment plan for your incontinence problem. Please answer the questions as completely as possible. The answers are completely confidential. If more than one answer is correct for you, circle all the answers that apply. We will review this together at your initial visit.

Please introduce yourself.
Name _______________________________________________
Address______________________________________________
____________________________________________
Date of Birth_______________________________________________
Home Phone _______________________________________________
Work Phone________________________________________________
Workplace____________________________________________
Primary Care Physician____________________________________

Tell us a little about yourself. _________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

1. When did your episodes of incontinence begin?

2. Did your episodes start?
   a. suddenly
   b. over a period of time

3. How often do you unintentionally lose your urine?
   a. less than once per week
   b. one time per week
   c. 2-3 times per week
   d. daily
   e. several times per day

4. Approximately how much urine is usually lost during each episode?
   a. a few drops
   b. enough to wet underwear
   c. enough to wet outer clothes
   d. enough to wet the floor

5. What is the most urine you lose?
   a. less than one teaspoon
   b. between 1 teaspoon and 1 cup
   c. greater than 1 cup

6. In order to deal with this urine loss, do you
   a. change your underwear with each episode
   b. wear a panty liner or mini-pad
   c. use facial tissues or toilet tissues
   d. use maxi-absorbent pads
   e. wear an absorbent panty or diaper

7. How often do you have to change your protective devices in a 24 hour period?

3/11/07
8. Do you leak continuously?  
   _____Yes   _____No

9. Do you have trouble making it to the toilet on time?  
   _____Yes   _____No

10. Do you lose urine when you have a strong urge to urinate?  
    _____Yes   _____No

11. Are you usually on your way to the bathroom when you lose urine?  
    _____Yes   _____No

12. Can you make it to the bathroom, but then lose urine just as you are getting to the toilet or removing your clothes?  
    _____Yes   _____No

13. How long can you postpone urination?  
   a. never  
   b. a few minutes  
   c. longer than 10 minutes

14. Do you lose urine when you:  
   a. lift heavy objects  _____Yes   _____No   _____Sometimes
   b. sneeze  _____Yes   _____No   _____Sometimes
   c. exercise  _____Yes   _____No   _____Sometimes
   d. cough  _____Yes   _____No   _____Sometimes
   e. are lying down  _____Yes   _____No   _____Sometimes
   f. are sitting  _____Yes   _____No   _____Sometimes
   g. are walking  _____Yes   _____No   _____Sometimes
   h. other  _____Yes   _____No   _____Sometimes

15. Does your incontinence worsen at specific times such as:  
   a. during your menses  _____Yes   _____No   _____Sometimes
   b. during colds  _____Yes   _____No   _____Sometimes
   c. other: ________________________________________________

16. Are you aware of leakage when it occurs?  
   _____Yes   _____No.

17. When you urinate, can you stop your stream of urine?  
   _____Yes   _____No

18. How much fluid do you drink in a 24 hour period?  
   a. 1-3 cups (24 oz.)  
   b. 4-6 cups (32-48 oz.)  
   c. 7-9 cups (56-72 oz.)  
   d. 10-12 cups (80-96 oz.)  
   e. 13 or more cups (104+)

19. Do you have problems with constipation?  
   _____Yes   _____No   _____Sometimes
20. Are you ever incontinent of stool?
   _____Yes   _____No     _____Sometimes
   if Yes, the consistency of the stool is:
   _____diarrhea
   _____hard
   _____normal

21. Have you ever been unable to control passing gas?
   _____Yes   _____No

22. Do you ever have to use a special maneuver or position to have a bowel movement?
   _____Yes   _____No
   if Yes, tell us what you do __________________________________________________________
   ______________________________________________________________________________

23. When you urinate, do you experience any of the following?
   Difficulty starting your flow of urine?  ______Yes  ____No  ____Sometimes
   Intense or sudden stream of urine?  ______Yes  ____No  ____Sometimes
   Slow, weak stream?  ______Yes  ____No  ____Sometimes
   Frequent voiding in small amounts?  ______Yes  ____No  ____Sometimes
   Pain or burning?  ______Yes  ____No  ____Sometimes
   Dribbling after you finish?  ______Yes  ____No  ____Sometimes
   Peel the need to urinate again?  ______Yes  ____No  ____Sometimes
   Blood in your urine?  ______Yes  ____No  ____Sometimes
   Need to bear down?  ______Yes  ____No  ____Sometimes

24. When you urinate, do you feel you have emptied your bladder completely?
   _____Yes   _____No   ____Sometimes

25. When you turn on a water faucet, do you feel the urge to urinate?
   _____Yes   _____No
   if Yes, Do you lose urine?
   _____Yes   _____No

26. Do you ever have to use special maneuvers or positions to completely empty your bladder?
   If Yes, tell us what you do _______________________________________________________
   ______________________________________________________________________________

27. Do you ever have to get up at night to empty your bladder?  _____Yes  _____No
   if Yes, how often?____________________________________________________________

28. Have you been treated for 3 or more urinary tract infections?
   _____Yes   _____No

29. Have you been treated for a urinary tract infection in the last 6 months?
   _____Yes   _____No
30. Have you ever had:
   a. multiple sclerosis   f. spinal cord injury
   b. diabetes             g. stroke
   c. myelodysplasia       h. radiation to the bladder or pelvis
   d. Parkinson's disease  i. urethral dilatation
   e. kidney stones        j. been catheterized

31. How many vaginal deliveries have you had?_______________________________________
   Did you have episiotomies/stitches?______Yes  ____No  ____Don’t know
   What was the weight of your largest child?_______________________________________
   What was your longest length of time in labor?
   a. 1-4 hours   d. 12-16 hours   g. 24-26 hours
   b. 4-8 hours   e. 16-20 hours   h. 26-30 hours
   c. 8-12 hours  f. 20-24 hours   i. 30 + hours

32. In your home, is the distance to get to a bathroom a problem:
   a. During the day  _______Yes  _______No
   b. During the night _______Yes  _______No

33. Do you have difficulty walking?______Yes  _______No

34. Have you ever noticed a bulge coming from your vagina?  _______Yes  _______No

35. Do you smoke?  
   _______Never  _______Currently  _______Quit

36. If you currently smoke or have smoked in the past, please tell us:
   _____# of years       _____average # of packs per day       _____date you stopped smoking

37. Do you drink any alcoholic beverages? If so, how many per week? ______________________

38. Does your incontinence interfere with:
   a. Your social life?  
   b. Your work?  
   c. Your sexual life?  
   d. Your financial well-being?  
   e. Family relationships?
   Never          Occasionally         Often           Always

39. How much do you avoid doing things because you are afraid of having an incontinent accident?
   a. not at all  
   c. quite a bit  
   b. a little  
   d. a lot

40. What is your attitude toward your incontinence?
   a. slight problem  
   c. big problem  
   b. minor problem  
   d. major problem
41. Do you do Kegel exercises?
   _____ Yes  _____ No  _____ Don’t know

42. If you do Kegel exercises, how often do you do them?
   a. daily   b. weekly  
   c. less than weekly

43. Do you do regular exercise or activity? If so, what? How often?
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

44. What is your occupation? ____________________________________________

45. Do you engage in lifting as part of your:
   a. employment  b. work at home  
   b. recreation  c. no lifting

46. Past Medical & Social History:
   List all serious illnesses in your immediate family (parents, grandparents, brothers, sisters, children)
   example: diabetes, tuberculosis, breast cancer, heart disease, etc.  
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

47. Please list all the medications you are currently taking each day (prescription and over the counter medications).

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dose</th>
<th>Times per day</th>
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<tbody>
<tr>
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48. List any drug allergies
   What is the reaction? ____________________________________________________________

49. List any personal past or present illnesses (i.e. – high blood pressure, diabetes, etc.)
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

50. Are you on a special diet?  _____Yes  _____No  If yes, please explain

51. List previous surgery or procedures __________________________________________
    __________________________________________
### Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

Please explain any Yes answers in space provided.

<table>
<thead>
<tr>
<th>Constitutional Symptoms</th>
<th>Cardiovascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Chest pain</td>
</tr>
<tr>
<td>Chills</td>
<td>Varicose veins</td>
</tr>
<tr>
<td>Headache</td>
<td>High blood pressure</td>
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<tr>
<td>Other</td>
<td>Other</td>
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<td></td>
<td>Explanations</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Eyes</th>
<th></th>
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<tbody>
<tr>
<td>Blurred vision</td>
<td>Y N</td>
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<tr>
<td>Double vision</td>
<td>Y N</td>
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<tr>
<td>Pain</td>
<td>Y N</td>
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<td>Other</td>
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<td>Explanations</td>
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<thead>
<tr>
<th>Allergic /Immunologic</th>
<th>Neurological</th>
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<tbody>
<tr>
<td>Hay Fever</td>
<td>Tremors</td>
</tr>
<tr>
<td>Drug allergies</td>
<td>Dizzy spells</td>
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<tr>
<td>Other</td>
<td>Numbness / tingling</td>
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<tr>
<td></td>
<td>Other</td>
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<td></td>
<td>Explanations</td>
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<table>
<thead>
<tr>
<th>Endocrine</th>
<th>Gastrointestinal</th>
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</thead>
<tbody>
<tr>
<td>Excessive thirst</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Too hot / cold</td>
<td>Nausea / vomiting</td>
</tr>
<tr>
<td>Tired/sluggish</td>
<td>Indigestion / heartburn</td>
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<tr>
<td></td>
<td>Other</td>
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<td>Explanations</td>
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<thead>
<tr>
<th>Respiratory</th>
<th>Hematologic/Lymphatic</th>
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<tbody>
<tr>
<td>Wheezing</td>
<td>Swollen glands</td>
</tr>
<tr>
<td>Frequent cough</td>
<td>Blood clotting problem</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Other</td>
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<td></td>
<td>Explanations</td>
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<tr>
<th>Psychologic</th>
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<tbody>
<tr>
<td>Are you generally satisfied with your life?</td>
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<tr>
<td>Do you feel severely depressed?</td>
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<tr>
<td>Have you considered suicide?</td>
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<tr>
<td>Other</td>
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Provider: ________________________________  Date: _____/_____/_____

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Provider use only (Comments / Notes)