Women's Continence and Pelvic Health Center

CHESHIRE MEDICAL CENTER
DARTMOUTH-HITCHCOCK • KEENE

Committed to Caring
580-590 Court Street
Keene, New Hampshire 03431
(603) 354-5454 Ext. 6643

URINARY INCONTINENCE

QUESTIONNAIRE

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?

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:

	Never	Occasionally	Often	Always
a. Your social life?	_____	_____	_____	_____
b. Your work?	_____	_____	_____	_____
c. Your sexual life?	_____	_____	_____	_____
d. Your financial well-being?	_____	_____	_____	_____
e. Family relationships?	_____	_____	_____	_____

39. How much do you avoid doing things because you are afraid of having an incontinent accident?'

a. not at all	b. a little
c. quite a bit	d. a lot

40. What is your attitude toward your incontinence?

a. slight problem	b. minor problem
c. big 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).

Medications	Dose	Times per day

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.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

Explanations_____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other_____

Explanations_____

Allergic /Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other

Explanations_____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness *I* tingling	Y	N

Other

Explanations_____

Endocrine

Excessive thirst	Y	N
Too hot *I* cold	Y	N
Tired/sluggish	Y	N

Other_____

Explanations

Gastrointestinal

Abdominal pain	Y	N
Nausea *I* vomiting	Y	N
Indigestion *I* heartburn	Y	N

Other

Explanations_____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other_____

Explanations_____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Explanations_____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Explanations_____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N

Other_____

Explanations_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other_____

Explanations _____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other_____

Explanations_____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other_____

Explanations_____

Provider use only (Comments *I* Notes)

Provider:_____ Date: _____/_____/_____