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Urinary incontinence questionnaire

Patient Name: …… Date of birth: ……

1. How often do you urinate during the day?……..……
2. How often do you get up at night to urinate? ……
3. Do you leak urine while coughing, sneezing, laughing, lifting, running? _ _No __Yes
4. Do you find it necessary to use some type of leakage protection? _ _No __Yes
5. Do you have usually a strong sense of urgency to urinate? _ _No __Yes
6. Do you ever lose urine when lying down? _ _No __Yes
7. Is the amount of urine you usually pass... __Large __Average __Small
8. Are there times when you don't make it to the bathroom and leak? __ _No __Yes
9. Do you experience any sensations before losing urine? _ _No __Yes
10. Can you overcome the sensation of the urgency to urinate? _ _No __Yes
11. When urinating, can you usually stop your stream? _ _No __Yes
12. Do you have difficulty starting your urine stream? _ _No __Yes
13. Do you feel you have completely emptied your bladder after urinating? _ _No __Yes
14. Do you dribble urine after voiding? _ _No __Yes
15. Were you ever catheterized because you were unable to void? _ _No __Yes
16. Do you ever pass blood in your urine? _ _No __Yes
17. Have you ever passed sand, gravel, or stones? _ _No __Yes
18. Do you have pain during urination? _ _No __Yes
19. Have you been treated for three or more urinary infections? _ _No __Yes
20. List all medications you have taken in the past six months
……

Patient signature: …… Date:……