BLADDER SURVEY

Name_____ **Date of Birth**_____ **Physician:**_____

Frequent urination

Do you feel like you void/urinate too frequently? □ no □ yes
How many times per day would you guess that you void/urinate? _____

Pain or burning with urination

Do you have pain/burning with urination?
Do you have a history of urinary tract infections? □ no □ yes
Do you have a history of positive urine cultures? □ no □ yes

Urinary urgency or the feeling you have to run to bathroom

Do you frequently get the feeling you must hurry to the bathroom to urinate? □ no □ yes

Urinary leakage or "accidents"

If so, is your leakage during the □ day □ night
Do you have leakage associated with coughing, sneezing, laughing or lifting? □ no □ yes
Do you have leakage when you can't get to the bathroom in time? □ never □ sometimes □ often
How many pads do you use in a day? _____ night? _____
How many babies have you delivered? _____ □ vaginal □ c-section

Urinate at night

How many times do you get up to urinate? _____

Have you tried medication to treat your bladder symptoms? □ **no** □ **yes**

if so, which medications have you tried? _____
_____

Have you had any procedures involving your kidneys, bladder or prostate? □ **no** □ **yes**

If so, what did you have done and what approximate year was it performed_____
_____

What is your most bothersome urinary complaint? _____

How bothersome are your bladder symptoms?

□ **Not very bothersome** □ **Somewhat bothersome** □ **Very bothersome**

Do you have any of the following?

□ **Constipation** □ **Diarrhea** □ **Both**

Films

Have you had any recent films (CT scan or ultrasound) of your abdomen or pelvis? □ no □ yes

IF so, what were they, and where did you have them done? _____