Bladder Testing Questionnaire for Women

Name: _____ **DOB:** _____

Referring Physician: _____

1. **During the last 3 months, have you leaked urine (even a small amount)?**
   - ☐ YES
   - ☐ NO (if NO go to Question #4)

2. **During the last 3 months, did you leak urine...(check all that apply):**
   - ☐ **a.** When you were performing some physical activity, such as coughing, sneezing, and lifting or exercise?
   - ☐ **b.** When you had the urge or the feeling that you needed to empty your bladder but you could not get to the bathroom fast enough?
   - ☐ **c.** Without physical activity and without a sense of urgency?

3. **During the last 3 months, did you leak urine most often...(check only one):**
   - ☐ **a.** When you were performing some physical activity, such as coughing, sneezing, and lifting or exercise?
   - ☐ **b.** When you had the urge or the feeling that you needed to empty your bladder but you could not get to the bathroom fast enough?
   - ☐ **c.** Without physical activity and without a sense of urgency?
   - ☐ **d.** About equally as often with physical activity as with a sense of urgency?

4. **Please check anything listed below that you have experienced in the last 3 months:**
   - ☐ **a.** Frequent urination
   - ☐ **b.** Nighttime urination (2 times or more)
   - ☐ **c.** Pain in or around your bladder
   - ☐ **d.** Pain or trouble urinating after intercourse
   - ☐ **e.** Bladder leakage during sexual intercourse
   - ☐ **f.** Bladder leakage during orgasm
   - ☐ **g.** Bladder leakage with washing hands, seeing or hearing running water
   - ☐ **h.** Bladder leakage that is continuous
   - ☐ **i.** Bladder leakage that you cannot sense until you notice wetness
   - ☐ **j.** Frequent bladder/urinary tract infections
   - ☐ **k.** Dropping bladder or bulging vagina
   - ☐ **l.** Bed wetting

5. **Please check anything listed below that has occurred in the last 3 months when you urinate:**
   - ☐ **a.** Slow or weak urine stream
   - ☐ **b.** Stream that starts and stops
   - ☐ **c.** Feeling that your bladder did not empty correctly
   - ☐ **d.** Dribbling after urination
   - ☐ **e.** Difficulty getting your urine stream started
   - ☐ **f.** Discomfort, burning or pain with urination
   - ☐ **g.** Using hand to push or press in or around your vagina/bladder to urinate
   - ☐ **h.** Stand up or change position to empty bladder
   - ☐ **i.** Strain to empty bladder