Bladder Symptom Questionnaire

Name: Date:

Doctor:

Which symptoms best describe you? Select all that apply.

- Frequent urination—day, night, or both
- Sudden or strong urge to urinate
- Leakage with little or no warning—sometimes unable to make it to the bathroom in time
- Unable to completely empty bladder—feels like there is more even after going to the bathroom
- Accidental leakage with physical activity—exercising, sneezing, or coughing
- Bladder or pelvic pain
- Problems with bowel function (if checked, please select symptom below)
  - Accidental loss or leakage of stool Constipation Other
- No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried?

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? Yes No

if no, why have you stopped taking them?

Did not work as well as expected Side effects Expense
Interaction with other medications Other

If Side effects or Other checked, please explain:

Behavior modifications tried?

(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physicial therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Select a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

Yes No

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