UROGYNECOLOGY PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Referring provider: _____ Gynecologist: _____ Last Apt: _____

If you were referred by a healthcare provider, may we send correspondence regarding your visit? ☐ Yes ☐ No

What bothers you most about your bladder or pelvic organs?

How long have you had this? _____ The problem is getting (Please circle one): worse better no change

1. Do you lose urine with any of the following activities: (Mark all that apply)

☐ Coughing	☐ Walking	☐ Lifting
☐ Exercise	☐ Sneezing	☐ Laughing
☐ Clearing your throat	☐ Running	☐ Standing up
☐ Orgasm	☐ Pressure during intercourse	☐ Washing your hands
☐ Seeing water	☐ Putting key in door	☐ Showering
☐ Cold weather	☐ Other: _____	☐ Other: _____

2. Which of the above situations are most bothersome? _____
3. How much does your urine loss bother you? (Please circle one) not-at all slightly moderately greatly
4. Do you ever lose urine while lying down? ☐ Yes ☐ No
5. Do you ever have a sudden urge to void and lose urine before you reach the toilet? ☐ Yes ☐ No
   If so, how much does this bother you? (Please circle one) not-at-all slightly moderately greatly
6. Circle the following word to best describe your urgency feeling when your bladder is full.
   (Please circle one) none mild moderate severe
7. Do you ever leak urine suddenly without an urge while sitting quietly? ☐ Yes ☐ No
8. Do you experience complete bladder emptying for no apparent reason? ☐ Yes ☐ No
9. Are you aware of the urine loss? ☐ Yes ☐ No
10. Did you have bedwetting problems beyond age 5? ☐ Yes ☐ No
11. Do you wake up wet at night? ☐ Yes ☐ No
12. Have you wet the bed in the past year? ☐ Yes ☐ No
13. Did your urine problems start after childbirth? ☐ Yes ☐ No
14. Did your urine problems start after an operation? ☐ Yes ☐ No
15. Did your urine problems start after X-ray treatment? ☐ Yes ☐ No
16. Do you dribble urine when you stand up or cough after voiding? ☐ Yes ☐ No
17. Do fits of laughter cause complete emptying of your bladder? ☐ Yes ☐ No
18. Do you lose urine in drops? ☐ Yes ☐ No
19. Do you lose urine in large amounts? ☐ Yes ☐ No
20. Do you lose urine in spurts? ☐ Yes ☐ No
21. Do you lose urine in constant stream? ☐ Yes ☐ No
22. How many times per day do you leak urine? _____
22. Do you use a protective pad? ☐ Yes ☐ No
    If so, how many per day _____ per night _____

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UROGYNECOLOGY continued...

23. Have you modified any of the following activities because of urine loss? ☐ Yes ☐ No

    (Circle any that apply) Travel Social activities Physical recreation (exercise, walking, sports) Other_____

24. Do you feel it is bad enough to consider surgery? ☐ Yes ☐ No
25. Do you have a strong desire to void often? ☐ Yes ☐ No
26. Do you void often for fear of leaking? ☐ Yes ☐ No
27. Do you void often because of bladder pain or fear of pain? ☐ Yes ☐ No
28. Do you have pain during voiding? ☐ Yes ☐ No

    If so, when does it occur: (Circle all that apply)

    Only at the end of voiding Only when an infection is found After voiding

29. Do you have pain as your bladder fills and decreased pain after voiding? ☐ Yes ☐ No
30. How many times do you void (urinate) during the day? _____
31. How many times do you awaken from sleep to void? _____
32. Does it take you a long time to start voiding? ☐ Yes ☐ No
33. Do you assume different positions to help empty your bladder? ☐ Yes ☐ No
34. Do you strain to empty your bladder? ☐ Yes ☐ No
35. Do you put pressure on the lower abdomen to start urination? ☐ Yes ☐ No
36. Is you stream weak or prolonged? ☐ Yes ☐ No
37. Do you have a sensation of incomplete emptying after voiding? ☐ Yes ☐ No
38. Does the stream start and stop during urination? ☐ Yes ☐ No
39. Do you feel vaginal or pelvic pressure? ☐ Yes ☐ No
40. Do you see or feel something protruding from the vagina? ☐ Yes ☐ No
41. Have you used a pessary (device to help up pelvic organs) in the past? ☐ Yes ☐ No
42. Do you press around the anus or in the vagina during bowel movements? ☐ Yes ☐ No
43. Do you have fecal staining on your underwear? ☐ Yes ☐ No
44. Do you lose control of intestinal gas (flatus)? ☐ Yes ☐ No
45. Do you lose control of liquid stool? ☐ Yes ☐ No
46. Do you lose control of formed stool? ☐ Yes ☐ No
47. Do you have problems with constipation? ☐ Yes ☐ No
48. Do you have blood in your stool? ☐ Yes ☐ No
49. Have you been treated for 3 or more bladder or kidney infections in your life? ☐ Yes ☐ No
50. Have you been treated for a bladder or kidney infection within the past year? ☐ Yes ☐ No

    If yes, how many infections have you had within the past year? _____

    When was the last infection? _____

51. Do they occur one or 2 days after intercourse? ☐ Yes ☐ No
52. Have the infections been diagnosed by urine culture? ☐ Yes ☐ No
53. Is your urine ever bloody? ☐ Yes ☐ No

    If so, is it painful when you notice the bleeding? ☐ Yes ☐ No

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GYN/OB UROGYNECOLOGY PATIENT QUESTIONNAIRE

UROGYNECOLOGY continued...

54. Have you ever passed gravel, sand, or stones in your urine? ☐ Yes ☐ No
55. Have you ever been treated for kidney or bladder tumors? ☐ Yes ☐ No
57. Do you have any discomfort with intercourse? ☐ Yes ☐ No
58. Do you have vaginal dryness with intercourse? ☐ Yes ☐ No
59. Are you or your partner having sexual difficulties or concerns? ☐ Yes ☐ No
60. Would you like treatment for any sexual concerns? ☐ Yes ☐ No
61. How many 8 oz. glasses of water do you drink a day? _____
62. How many 8 oz glasses of other fluids do you drink a day? _____

What types of fluids other than water do you normally drink in a day?

Coffee ___ oz Tea ___ oz Soda ___ oz Alcoholic beverage ___ oz Fruit juice ___ oz

63. Have you had any prior treatment for urinary leakage? ☐ Yes ☐ No
64. Have you had an operation for urinary leakage? ☐ Yes ☐ No
65. Have you ever taken any medication for urinary leakage? ☐ Yes ☐ No
66. Please list any other treatments you have had for urinary leakage: _____
67. Do you have mitral valve prolapse? ☐ Yes ☐ No
68. Do you have an artificial valve? ☐ Yes ☐ No
69. Do you ever use antibiotics before any procedure for any reason? ☐ Yes ☐ No

If yes, please list the reason(s): _____

70. How many pregnancies have you had? _____
71. How many vaginal deliveries have you had? _____
72. How many Cesarean deliveries have you had? _____
73. Were forceps used for any of your deliveries? ☐ Yes ☐ No
74. Did you have an episiotomy for any of your deliveries? ☐ Yes ☐ No
75. What was the birth weight of your largest baby? _____
76. When was your last childbirth? _____
77. What is the date of your last menstrual period? _____
79. What is the date of your last Pap smear? _____
80. What is the date of your last mammogram? _____
81. Are you menopasual? ☐ Yes ☐ No

If so, have you ever taken hormones? ☐ Yes ☐ No

Are you currently taking hormones? ☐ Yes ☐ No

82. If you had previously taken hormones, but are not now, when did you stop taking them? _____
83. If you had previously taken hormones, but are not now, why did you stop taking them?_____
84. Do any family members have a history of urine loss? ☐ Yes ☐ No

If so, what relationship? _____

85. Do any family members have a problem with vaginal prolapse or protrusion? ☐ Yes ☐ No

If so, what relationship? _____

Patient Signature: _____ Date: _____

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