

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
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**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, physical 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
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**Not
Frustrated**

**Very
Frustrated**

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

Yes No