FEMALE UROLOGY QUESTIONNAIRE

Do you now or have you had any recent problems related to the following systems?

Urinary Incontinence (leakage)

How often do you experience urinary leakage (please circle one)

Never. I do not leak	Less than once a month	A few times a month	A few times a week	Every day and/or night
0	1	2	3	4

How much urine do you lose each time (please circle one)

None. I do not leak	Drops	Small splashes	More
0	1	2	3

Office use only

ISI Score (multiply Q1xQ2)

None Slight (1-2) Moderate (3-6)

Severe (8-9) Very Severe (10-12)

*Circle **Yes** or **No***

Leaking with cough, laugh, movement? Y N

Leaking with urgency (can't get to toilet in time) Y N

Do you wear pads due to leaking Y N

How many in 24 hours _____

What kind/type _____

Overactive Bladder symptoms

Excessive urge to urinate Y N

Excessive frequency of urination Y N

How many urinations in 24 hours _____

When you have the urge to urinate, how long can you delay? ____seconds____minutes____hours____not at all

Average fluid intake per day (1 glass is 8oz/1cup) _____glasses/day

How many cups of caffeinated beverages per day? _____glasses/day

Circle any foods/drinks you commonly enjoy:

Coffee Tea Cola Soda Spicy Foods Citrus Fruits/Juice (orange, lemon, etc) Tomato MSG
Artificial sweeteners Alcohol Chocolate Pickled Foods Indian/Mexican/Thai foods

Pain

Describe the pain_____

With urination Y N

Relieved by urination Y N

Pelvic Organ Prolapse symptoms

Pressure in lower abdomen Y N

Heaviness/dullness in the pelvis Y N

Sensation of incomplete emptying Y N

Have to push on a vaginal bulge to start or complete urination Y N

Bulge or something you see or feel falling out of the vaginal area Y N

Have to push on the vagina or around the rectum to have or complete a bowel movement Y N