



MetroHealth Medical Center
DIVISION OF UROGYNECOLOGY &
RECONSTRUCTIVE PELVIC SURGERY
MINIMALLY INVASIVE SURGERY

Questionnaire & Bladder Chart

PLEASE ANSWER EACH QUESTION TO THE BEST OF YOUR ABILITY. THIS INFORMATION IS IMPORTANT IN HELPING YOUR PHYSICIAN IN THE DIAGNOSIS AND TREATMENT OF YOUR BLADDER AND/OR PELVIC FLOOR PROBLEMS.

NAME: _____ Med. Rec #: _____

DATE OF BIRTH: _____ AGE: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

PATIENT HISTORY

Please describe the main reason you are seeing us today:

Please list any other medical problems you may have, such as high blood pressure, diabetes, etc.:

Please list the surgeries you have had and the approximate dates of each one:

Medications taken daily or regularly:

Please list any allergies:

How many times have you been pregnant? _____

How many vaginal deliveries have you had? _____

How much did your largest child weigh at birth? _____

Have you reached menopause yet? _____

If yes, do you currently take hormonal therapy? _____

When was your last Pap smear? _____

Was it normal? _____

Do you smoke? _____ Number of packs/cigarettes per day _____

Did you ever smoke? _____ How many packs per day did you smoke? _____

When did you quit? _____

Do you drink caffeinated coffee or tea? _____ If yes, how much per day? _____

Do you drink caffeinated soda? _____ If yes, how much per day? _____

What is/was your occupation? _____

BLADDER HISTORY

Please describe your bladder habits. Check **all** that apply.

Do you ...

___ leak with "stress." (Sneezing, coughing, lifting, running, etc.)

___ leak without being aware of it.

___ leak during sexual intercourse.

___ leak continuously.

___ leak or dribble immediately after emptying your bladder.

___ often experience a strong urge to urinate?

___ leak when you get the urge to void.

___ awaken at night because you have to go to the bathroom to urinate?

If yes, how many times per night? _____

___ ever experience urinary leakage while you sleep?

___ feel like your bladder has dropped?

___ feel a bulge or pressure in your vagina?

___ see a bulge coming out of your vagina?

___ have difficulty starting urination/voiding?

___ have an abnormal urine stream?

___ have difficulty emptying your bladder completely?

___ have to change positions to urinate?

On average, how long do you go between bathroom trips during the day?

___ Less than 1 hour

___ 1-2 hours

___ 2-4 hours

___ More than 4 hours

Number of pads or diapers worn on a daily basis.

___ None
 ___ Pads ___ # per day
 ___ Diapers ___ # per day

Please check the **one** best response.

How often do you experience urinary leakage?

- Never
- Less than once a month
- A few times a month
- A few times a week
- Every day and/or night

How much urine do you lose each time?

- Drops
- A few splashes
- More than a few splashes or drops

INCONTINENCE IMPACT ON YOUR QUALITY OF LIFE

Please circle your response

	Not at all	Less than half the time	About half the time	More than half of the time	Almost always
1. Over the past month has the leakage of urine and/or prolapse affected your ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3	4
2. Over the past month has the leakage of urine and/or prolapse affected your physical recreation such as walking, swimming, or other exercise?	0	1	2	3	4
3. Over the past month has the leakage of urine and/or prolapse affected your ability to attend entertainment activities (movies, concerts, etc.)?	0	1	2	3	4
4. Over the past month has the leakage of urine and/or prolapse affected your ability to travel by car more than 30 minutes from home?	0	1	2	3	4
5. Over the past month has the leakage of urine and/or prolapse affected your participation in social activities outside your home?	0	1	2	3	4
6. Over the past month has the leakage of urine and/or prolapse affected your emotional health (nervousness, depression, etc.)?	0	1	2	3	4
7. Over the past month how many times has the leakage of urine and/or prolapse made you feel frustrated?	0	1	2	3	4

BOWEL HABITS

Please check or circle the correct response.

In the past three months....

Do you often have discomfort or pain in your abdomen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely
Do you have less than 3 BMs per week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely
Do you have hard or lumpy stools at least 25% of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely
Do you have a feeling of incomplete emptying after a bowel movement at least 25% of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely
Do you have a sensation that the stool cannot be passed (i.e. is blocked) when having a bowel movement at least 25% of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely
Do you feel the need to press on or around your bottom or vagina to try to remove stool in order to complete the bowel movement at least 25% of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely
Do you have difficulty relaxing or letting go to allow the stool to come out at least 25% of the time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No or rarely

Do you have difficulty with bowel control?

- Never
- Occasionally, with gas
- Occasionally, with gas and stool
- Yes, I have trouble with leakage of stool

SEXUAL ACTIVITY

Are you currently sexually active? _____

- Yes
- No,
- No, no partner

Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out)?

- Always
- Usually
- Sometimes
- Seldom
- Never

Do you leak urine or stool during sexual activity?

- Always
- Usually
- Sometimes
- Seldom
- Never

Does fear of leakage (either stool or urine) restrict your sexual activity?

- Always
- Usually
- Sometimes
- Seldom
- Never