

UROLOGY PATIENT INCONTINENCE QUESTIONNAIRE (page 1 of 3)

Name: _____ Date: _____ Age: _____

Referring Physician: _____

The following information is CONFIDENTIAL. Information contained here will not be released to anyone without your authorization to do so.

CHIEF COMPLAINT INCONTINENCE

1. How long have you had the problem of urinary leakage? _____
2. Do you lose urine with any of the following: Laughing _____ Lifting _____
Active exercise _____ Minimal exercise like walking or light
housework _____ Sleeping _____ Nervousness or increased
anxiety _____ Leakage unrelated to any specific cause _____
3. Does your clothing get: damp _____ wet _____ soaking wet _____
4. Do you use: sanitary napkins _____ toilet/tissue paper _____ diapers _____
5. How many protective pads do you change per day? _____
6. Are they: damp _____ wet _____ saturated _____ at each change? _____
7. Do you leave puddles of urine on the floor? _____
8. Do you lose urine by continuous dribbling? _____
9. Do you lose urine in small spurts? _____
10. If "yes", is the loss of urine related to physical activity? _____
11. Do you lose urine in sudden, large amounts as if your whole bladder has emptied uncontrollably? _____
12. When you have the desire to urinate do you lose urine before you can get to the bathroom or toilet? _____
13. If "yes," does the urine loss occur every time _____, half the time _____, or only occasionally _____?
14. How has the problem of incontinence affected your quality of life? _____

PHYSICIAN USE ONLY

Present History (location, quality, severity, timing, content, modifying factors, associated symptoms)

Answers

1 - 3

4+

Level of Service

1 or 2

3 - 5

UROLOGY PATIENT INCONTINENCE QUESTIONNAIRE (page 2 of 3)

Patient's Name: _____ **Date:** _____

15. Do you have any other significant medical problems? Please list:
a) _____ b) _____ c) _____

16. List all of the surgeries you have ever had: a) _____ b) _____
c) _____ d) _____ e) _____

17. Are you **ALLERGIC** to any medications? a) _____ b) _____
c) _____ d) _____ e) _____

18. List the NAMES (and DOSE if known) of the medications you take daily, including **Aspirin**:
a) _____ b) _____ c) _____
d) _____ e) _____ f) _____

19. Have you ever had a blood transfusion? Yes _____ No _____

SOCIAL HISTORY

20. Are you: single _____ married _____ widowed _____ separated _____ other _____

21. Do you have a living will? Yes _____ No _____

22. What is your occupation? _____

23. Do you smoke cigarettes? Yes _____ No _____ How much? _____ How often? _____

24. Do you drink alcohol? Yes _____ No _____ How much? _____ How often? _____

25. Caffeine use? 1-2 cups/day _____ >3 cups /day _____

FAMILY HISTORY (Have you or any member of your family had cancer or any other disease of the kidney, bladder, prostate or testicles?)

Father _____ Mother _____ Brother _____ Sister _____ Children _____ Self _____

PHYSICIAN USE ONLY	# Answers	Level of Service
	0	1 or 2
	1 - 2	3
	3	4 or 5

UROLOGY PATIENT INCONTINENCE QUESTIONNAIRE (page 3 of 3)

Patient's Name: _____ Date: _____

Do you now, or have you ever had any problems related to the following systems? Please circle.

1. General – Any changes in:

- Appetite
- Weight
- Chills
- Fever
- Sweat

2. Head

- Chronic Headaches
- Head Trauma

3. Eyes

- Visual Changes
- Double Vision
- Blurred Vision

4. Ears, Mouth, Nose, Throat

- Ear Ringing
- Hearing Loss
- Bleeding from Nose or Gums
- Chronic Hoarseness

5. Lungs

- Chronic Cough
- Shortness of Breath
- Wheezing
- Asthma

6. Heart

- Chest Pain (Angina)
- Heart Murmurs (requiring antibiotic prophylaxis)
- Heart Attack

7. Gastro-intestinal

- Chronic Nausea or Vomiting
- Chronic Diarrhea
- Chronic Constipation
- Rectal Bleeding
- Ulcers

8. Genito-urinary

- Bleeding
- Chronic Urinary Infections
- Incontinence
- Infertility
- Kidney Stones
- Frequent Urination

9. Muscular-skeletal

- Chronic Pain
- Muscle Weakness
- Joint Swelling
- Backache

10. Neurological

- Chronic Dizziness
- Stroke
- Seizures

11. Skin

- Chronic Rashes
- Non-healing Ulcers

12. Psychiatric

- Increased Nervousness
- Mood Changes
- Chronic Depression

13. Endocrine

- Thyroid problems
- Heat or Cold Intolerance
- Diabetes
- Excessive Thirst
- Excessive Hunger

Please explain any other condition if not mentioned above:

PHYSICIAN USE ONLY

# Answer	Level of Service
0 – 1	1 or 2
2 - 9	3
10+	4 or 5