Urodynamics Questionnaire

Patient Name: _______________________________ Date: __________________
Referring MD: _______________________________ Your Age: ________________

Please describe your bladder control problem: __________________________________________
________________________________________________________________________________
________________________________________________________________________________
When you’re your problem start? ______________________________________________________

Medical History: Please indicate if you have:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
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<tr>
<td>Depression</td>
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<tr>
<td>Kidney Infections</td>
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<tr>
<td>Multiple Sclerosis</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bladder infections</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Polio</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Back Problems</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Any other conditions:
List any medications including hormones, diet pills, decongestants and prescription medication that you take: __________________________________________________________
___________________________________________________________________________

What allergies do you have?: ________________________________________________

Gynecology history:

How many vaginal deliveries have you had? __________________

How many cesarean sections have you had? __________________

Are you in menopause? Y N Since when: ________________________________

List any surgeries you have had: _____________________________________________
___________________________________________________________________________

Symptoms:

How many times during the day do you urinate? ______

How many times do you void during the night after going to bed? _______

Do you wear a pad because of your leaking? Y N

Do you leak urine when you cough, sneeze or laugh, or exercise? Y N

When you are urinating, can you usually stop the flow? Y N

Have you changed your activities because of the leakage? Y N

Do you ever have an uncomfortably strong need to urinate before you empty your bladder? Y N

Can you overcome this urge? Y N

Do you leak urine on the way to the bathroom? Y N

Do you have to hurry to the bathroom? Y N

Does the sound or feel of running water cause you to lose urine? Y N

Do you have to strain to pass your urine? Y N

After you urinate, do you have dribbling? Y N

After you urinate do you have a feeling that your bladder is still full? Y N

Have you wet your bed in the past year? Y N

Do you purposely limit your fluid intake? When? Y N