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Urodynamics Questionnaire

Patient Name: ____Date: __________________
Referring MD: ____ Your Age: ______________

Please describe your bladder control problem: ____
____
____Wheny
ou're your problem start? ____

Medical History: Please indicate if you have:

Cancer	Y	N	Diabetes	Y	N
Depression	Y	N	High blood pressure	Y	N
Kidney Infections	Y	N	Bladder infections	Y	N
Multiple Sclerosis	Y	N	Polio	Y	N
Stroke	Y	N	Back Problems	Y	N

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 to 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