Associates for Women's Medicine

1.	How many times do you urinate during the day?	_____	
2.	How many times do you get up at night to urinate?	_____	
3.	Do you leak every day?	Y	N
4.	Do you find it necessary to wear a pad?	Y	N
5.	Do you leak urine when you cough, sneeze, laugh, run or jump?	Y	N
6.	Does your urine simply run out when you stand up?	Y	N
	a. Do you experience any sensation before losing urine?	Y	N
	b. When urinating, can you stop your stream?	Y	N
7.	Do you have a strong sense of urgency to urinate?	Y	N
	a. Do you have to hurry to empty your bladder when full?	Y	N
	b. Can you overcome the sensation of urgency to urinate?	Y	N
	c. Does the sight, sound or feel of running water cause you to lose urine?	Y	N
	d. Have you wet your bed during the past year?	Y	N
8.	Do you have difficulty starting your urine stream?	Y	N
	a. Do you feel you completely empty your bladder?	Y	N
	b. Do you dribble urine after voiding?	Y	N
9.	Were you ever catheterized because you were unable to void?	Y	N
	a. Have you ever had your urethra dilated or stretched?	Y	N
	b. Do you ever pass blood, sand, gravel or stones?	Y	N
	c. Do you have pain during urination?	Y	N
10.	Have you been treated for 3 or more urinary tract infections?	Y	N
	a. Have you been treated within the past 6 months?	Y	N
11.	Did your difficulty begin:		
	a. During pregnancy?	Y	N
	b. Following a delivery?	Y	N
	c. Following an abdominal or vaginal operation?	Y	N
	d. After menopause?	Y	N
12.	Have you changed your physical or social activities as a result of your urinary leakage?	Y	N

13. List all medications you have taken in the past 6 months. Circle those you are presently taking.

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14. Comments:

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