Janice Webber Physiotherapy Services

Urinary Symptoms Questionnaire

Name: _____ Date: _____

Describe the reason for your appointment _____
When did this problem begin? _____ is it getting better? _____ worse? ____ staying the same? _____
List the activities or things that you cannot do because of this problem _____
_____

Bladder leakage frequency – no. of episodes Never Only with strong cough/sneeze Only with premenstrual ___# per month ___# per week ___# per day Constant leakage	Severity of leakage No leaks Few drops Wets underwear Wets outerwear
Protection worn None Tissue paper/paper towel Pantisheilds Minipads Maxipads Specialty product name _____ Diaper	Leakage cause or increased by Vigorous activity or exercise (running, wt. lifting) Light activity (walking, light housework) Changing positions (sit to stand) Walking to toilet Strong urge to go Intercourse or sexual activity No activity changes leakage (constant despite activity) Other, please list _____
Position or activity with leakage Lying down Sitting Standing	How long can you delay the need to urinate? Not at all 1-2 minutes 3-10 minutes 11-30 minutes 31-60 minutes _____ hours
Rate of feeling of “falling out” or pelvic heaviness/pressure None present ___times per month Only with menstruation With standing With exertion or straining At end of each day Present all day	Fluid intake (one glass = 8 oz or 1 cup) _____glasses per day # of caffeinated glasses ____ per day # of alcoholic beverages ____ per day

Rate your feelings as to the severity of this problem. 0= no problem, 10= the worst

0_____10

Rate the following statement as it applies to you today:

My bladder is controlling my life. 0 = no, 10 = yes

0_____10

Bladder Habits

How often do you urinate during the day?	____ # of times
How often do you urinate after going to bed?	____ # of times
Do you take your time to go to the toilet and empty your bladder?	____ yes ____ no
Number of bladder infections in the last year?	
Can you stop the flow of urine when on the toilet?	____ yes ____ no
What volume do you usually pass when urinating?	large___ average___ small___ very small ___
Do you have the sensation that you need to go to the toilet?	____ yes ____ no
Do you have to empty your bladder frequently before you experience the urge to pass urine?	____ yes ____ no
Do you have the feeling your bladder is still full after urinating?	____ yes ____ no
Do you have a slow or hesitant urinary stream?	____ yes ____ no
Do you have difficulty initiating the urine stream?	____ yes ____ no
Do you have "triggers" that make you feel like you cannot wait to go to the toilet? (running water, etc.)	____ yes, please list ____ no

Bowel Habits

Frequency of bowel movements	____ per day ____ per week
Consistency of stool	loose___ normal____ hard___
History of constipation?	____ yes ____ no
Do you have to strain to go?	____ yes ____ no
Do you ignore the urge to defecate?	____ yes ____ no
Do you have trouble making it to the toilet on time when you have the urge to go?	____ yes ____ no
Are you able to go in public toilets?	____ yes ____ no