UROGYNECOLOGY
SAN ANTONIO

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FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY

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Name: Date:

Doctor:

Which symptoms best describe you?

Frequent urination — day, night, or both
Sudden or strong urge to urinate
Leakage with little or no warning — sometimes unable to make it to the bathroom in time
Unable to completely empty bladder — feels like there is more even after going to the bathroom
Accidental leakage with physical activity — exercising, sneezing, or coughing
Bladder or pelvic pain
Problems with bowel function (if checked, please select symptom below)
Accidental loss of leakage or stool Constipation Other
No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried?

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select a number.

1	2	3	4	5	6	7	8	9	10

No Relief **Complete Symptom Relief**

Are you still taking any of these medications? Yes No

If no, why have you stopped taking them?
Did not work as well as expected Side effects Expense
Interaction with other medications Other

If you checked Side effects or Other, please explain:

Behavior modifications tried?
(i.e, reduced fluid intake, caffeine reduction, Kegal exercises, physical therapy, or lifestyle changes)

On a scale of 1 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Select a number.

1	2	3	4	5	6	7	8	9	10

Not frustrated **Very frustrated**

Are you interested in learning more about additional treatment alternatives to bladder medications? Yes No