St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL

Steward

Bladder Control Problem

1. How many times do you go to the bathroom during the day? _____ At night? _____
2. How long have you had this problem? _____ weeks _____ month's _____ years
3. How bad is the problem? _____ Mild _____ Moderate _____ Severe
4. Have you stopped doing activities, sports, social activities etc. due to your bladder problems?
   _____ Yes _____ No
5. Have you ever taken medication to fix the problem? If yes, please list all meds taken. _____ No
   _____ Yes _____
6. Have you ever had surgery to fix the problem?
   *If yes, please list surgeries and when you had them done.
   _____ No _____ Yes _____
7. Do you have a history of urinary tract infections? _____ Yes _____ No
   Blood in your urine? _____ Yes _____ No
   Kidney Stones? _____ Yes _____ No

Please fill out this portion ONLY if you experience urine leakage.

8. How many times a day do you leak? _____ Times per day
9. How much do you leak? _____ damp _____ very damp _____ wet _____ soaked
10. Do you get a strong urge to urinate before you leak? _____ Yes _____ No

Check all that apply:

11. Do you leak when you
    _____ cough _____ during intercourse _____ vigorous exercise
    _____ laugh _____ fast running _____ walking
    _____ sneeze _____ lift something _____ slightest movement
12. How many pads per day do you wear? _____ pads per day