



## FEMALE UROLOGY QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Urinary Incontinence (leakage)

How often do you experience urinary leakage (please circle one)

Never I do not leak	Less than once a month	A few times a month	A few times a week	and/or night
0	1	2	3	4

How much urine do you lose each time (please circle one)

Never I do not leak	Drops	Small splashes	More
0	1	2	3

**For office use only:**

ISI Score = \_\_\_\_\_  
 (Multiply Q1 x Q2)

None/Slight = 1 – 2  
 Moderate = 3 – 6

Severe = 8 – 9  
 Very Severe = 10–12

Do you wear pads due to leaking **Yes** **No**  
 How many in 24 hours \_\_\_\_\_  
 What kind/type/brand \_\_\_\_\_  
 Leaking with cough, laugh, movement? **Yes** **No**  
 Leaking with urgency (can't get to toilet in time) **Yes** **No**

### Overactive Bladder Symptoms

Excessive urge to urinate **Yes** **No**  
 Excessive frequency of urination **Yes** **No**  
 How many urinations in 24 hrs \_\_\_\_\_

When you have the urge to urinate, how long can you delay? \_\_\_seconds \_\_\_minutes \_\_\_hours \_\_\_not at all

Average fluid intake per day (1 glass is 8oz/1 cup) \_\_\_\_\_ glasses/day

How many cups of caffeinated beverages per day \_\_\_\_\_ glasses/day

### Circle any foods/drinks you commonly enjoy:

Coffee      Tea      Cola      Alcohol      Citrus Fruits/Juices (orange, lemon, & etc.)  
 Tomato      Spicy Foods      Chocolate      Pickled Foods      Artificial Sweeteners

**Pain** Describe the pain \_\_\_\_\_

With urination **Yes** **No**  
 Relieved by urination **Yes** **No**

### Pelvic Organ Prolapse Symptoms

Pressure in lower abdomen **Yes** **No**  
 Heaviness/dullness in the pelvis **Yes** **No**  
 Sensation on incomplete emptying **Yes** **No**  
 Have to push no vaginal bulge to start or complete urination **Yes** **No**  
 Bulge or something you see or feel falling out of the vaginal area **Yes** **No**  
 Have to push on the vagina or around the rectum to have or complete bowel movement **Yes** **No**