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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 = 0 _____ (*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/1cup) _____ 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 No 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**