Bladder Symptom Questionnaire

PNE

Name: _____ Date: _____

Urologist: _____ D.O.B.: _____ Phone: _____

Which Symptoms Best Describe You? (check all that apply):

☐ 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 or leakage of 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 o to 10, 0 Being <u>NO</u> Symptom Relief and 10 Being <u>COMPLETE</u> Symptom Relief, How Much Symptom Relief Have These Medications Provided You? (place a check below the number that matches your level of relief):

No Relief ----------Complete Symptom Relief

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are You Still Taking 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

On a Scale of 0 to 10, 0 Being No Frustration at all and 10 Being Extremely Frustrated, What is Your Level of Frustration with You Bladder Control Symptoms? (place a check below the number that matches your level of frustration):

Not Frustrated ----------Extremely Frustrated

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are You Interested in Learning More About Additional Treatment Alternatives to Bladder Medications?:

☐ Yes ☐ No

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