

Urinary Incontinence Evaluation

Name: _____

Date: _____
Age: _____

Summary of Incontinence

Onset _____

Treatments _____

Self-help techniques _____

Bladder Diary _____ days

Accidents _____

Voids _____

Pad Changes _____

UI symptoms

(precipitants, impact, frequency, amount, voiding probs., bowel)

ROS

(neurologic (stroke, Parkinson's, memory loss), diabetes, CHF, obesity)

Positives

(history, habits, pregnancies)

Medication Review

(note beta blocker, sedative, narcotic, diuretic, anticholinergic, calcium channel blockers, OTC, cold remedy, herbals)

Habits

(circle all that apply)

Caffeine _____

Fluids per day _____ oz

Bedtime fluids _____ oz

Alcohol _____/day

Tobacco _____/day

Bowels

Straining _____

<3/wk. _____

7 days between _____

Enemas/lax _____

Incontinence _____

GU Hx.

Bladder tumor _____

Pelvic XRT _____

Rec. UTI _____

Kidney stones _____

Women only

No. of Pregnancies _____

Menopause? Y N _____

Age _____

(circle all that apply)

Estrogens _____

FHx. CA breast _____

Suspension _____

Dilatation _____

Hysterectomy _____

Ovaries out _____

Men only

Prostate surgery _____

Retention _____

IIQ-7

Chores _____

Recreation _____

Entertain _____

Travel _____

Social _____

Emotional _____

Frustration _____

Total _____

Precipitants

(circle all that apply)

Change position _____

Running _____

Sneeze, cough _____

Laugh _____

Lift _____

Bend down _____

Reaching _____

Rush to toilet _____

Running water _____

Wash hands _____

Voiding Problems

(circle all that apply)

Damp w/o recog _____

Can hold:

Indefinitely _____

Few minutes _____

Minute or two _____

No full sensation _____

Nocturia _____

Trouble with:

Starting _____

Slow stream _____

Discomfort _____

Hematuria _____

Inc. emptying _____

Vital Signs	BP _____	P ___ T ___	Wt. ___ lb	Ht. ___ in
Eyes <input type="checkbox"/> NI conjunctiva & lids Pupils <input type="checkbox"/> Pupils symmetrical, reactive Fundus <input type="checkbox"/> NI discs & pos elements	External genitalia <input type="checkbox"/> Skin irritation? <input type="checkbox"/> None Sensation <input type="checkbox"/> Normal fine touch Findings			
ENT-External <input type="checkbox"/> No scars, lesions, masses Otoscope <input type="checkbox"/> NI canals & timpanic membranes Hearing <input type="checkbox"/> NI to _____ Neck palp. <input type="checkbox"/> Symmetrical without masses Thyroid <input type="checkbox"/> No enlargement or tenderness	GU female Int. inspection <input type="checkbox"/> NI bladder, urethra, & vagina Uterus <input type="checkbox"/> NI size, position, w/o tenderness Adnexa <input type="checkbox"/> No masses or tenderness Pelvic mm. <input type="checkbox"/> NI pressure, displacement, duration Provocative test <input type="checkbox"/> No loss with cough, stand, heel bounce Findings (inflammation, prolapse, weakness)			
Resp. effort <input type="checkbox"/> NI without retractions Chest percuss. <input type="checkbox"/> No dullness or hyperresonance Chest palp. <input type="checkbox"/> No fremitus Auscultation <input type="checkbox"/> NI bilateral breath sounds w/o rales				
Heart palp. <input type="checkbox"/> NI location, size Cardiac ausc. <input type="checkbox"/> No murmur, gallop, or rub Carotids <input type="checkbox"/> NI intensity w/o bruit Pedal pulses <input type="checkbox"/> NI posterior tibial & dorsalis pedis				
Breasts <input type="checkbox"/> NI inspection & palpation	Rectal examination Sphincter <input type="checkbox"/> Normal appearance and squeeze Stool? <input type="checkbox"/> None in rectum Males only Prostate <input type="checkbox"/> Normal size, no nodules Rectal Findings:			
Abdomen <input type="checkbox"/> No masses or tenderness L/S <input type="checkbox"/> No liver/spleen palpable Hernia <input type="checkbox"/> No hernia identified Bladder <input type="checkbox"/> Not enlarged MS Gait <input type="checkbox"/> NI gait & station Nails <input type="checkbox"/> No clubbing, cyanosis	Residual urine volume: _____ ml. by: cath US Urinalysis <input type="checkbox"/> Normal Findings: _____			
Neurologic <input type="checkbox"/> NI alertness, attentive Cranial nerves <input type="checkbox"/> w/o gross deficit Coordination <input type="checkbox"/> NI rapid alternating movement DTR's <input type="checkbox"/> Symmetrical, ___ (scale: 0-4+) Sensation <input type="checkbox"/> NI touch, proprioception				

Diagnostic Assessment

Plan (Behavioral, medications, education, referral, follow-up)