Incontinence Patient Information Form

(To be completed by patient)

Before talking with you, the doctor would like some information about your urine leakage. These questions are important for finding out what is causing the leakage. The doctor will discuss some of your answers during your visit.

What changes would you like to see in your symptoms as a result of your treatment here?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Description of Urine Leakage

1. How long have you had urine leakage?

________________________________________________________________________

2. Have you ever been treated for your bladder leakage?

________________________________________________________________________

3. Circle all treatments that you have received in the past.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic muscle exercises</td>
<td>Electrical stimulation</td>
</tr>
<tr>
<td>Bladder training</td>
<td>Other?</td>
</tr>
</tbody>
</table>

________________________________________________________________________

________________________________________________________________________
Description of Urine Leakage, continued

4. Circle all self-help techniques you have tried.
   - Pads/diapers
   - Drink less fluids
   - Go to the toilet often
   - Stay near a bathroom

5. Other self-help techniques?

6. How often do you leak urine?

7. How much urine do you leak each day?

Activities Leading to Urine Leakage

Circle how often each of the following activities leads to a loss of urine.

1. Changing position from sitting, or standing up
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always
   - Not able

2. Running
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always
   - Not able

3. Sneezing or coughing
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always
   - Not able

4. Laughing
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always
   - Not able
Activities Leading to Urine Leakage, continued

5. Lifting
   Never   Rarely   Sometimes   Often   Always   Not able
   
6. Bending Down
   Never   Rarely   Sometimes   Often   Always   Not able
   
7. Reaching
   Never   Rarely   Sometimes   Often   Always   Not able
   
8. Rushing to toilet
   Never   Rarely   Sometimes   Often   Always   Not able
   
9. Running water
   Never   Rarely   Sometimes   Often   Always   Not able
   
10. Washing your hands
    Never   Rarely   Sometimes   Often   Always   Not able
    
11. Do you ever find yourself wet or damp and you did not realize you had an accident?
    Never   Sometimes   Always
    
12. Once your bladder feels full, how long can you hold your urine?
    As long as I want   A few minutes
    Less than a minute or two   Cannot tell when bladder is full
Activities Leading to Urine Leakage, continued

13. Do you wake up in the night to urinate?

Yes No

If yes, how often?

14. Circle any of the following that occur when you urinate.

a. Difficulty in getting urine started
b. Very slow stream or dribbling
c. Discomfort or pain
d. Blood in the urine
e. Feeling that your bladder did not empty completely

Fluid Intake and Smoking

(cup = 6 oz; glass = 8 oz; mug = 12 oz)

1. Do you drink coffee, tea, or soda products with caffeine?

Yes No

How much? oz.

2. How many glasses of fluid do you drink each day (including the caffeinated beverages you mentioned above)?

3. How much fluid do you drink in the two hours before you go to bed?

oz.
Fluid Intake and Smoking, continued

4. Do you drink alcohol?
   Yes                       No

   If yes, about how much do you drink each day?
   (1 drink = 12 oz. beer, 6 oz. wine, 2 oz. hard liquor)

5. Do you smoke cigarettes?
   Yes                       No

   If yes, about how many packs do you smoke each day?

   How many years have you smoked?

Bowel Control

1. Circle any of the following problems you have experienced with your bowels.
   a. Straining on more than one quarter of bowel movements
   b. Stool frequency less than 3 times per week
   c. Longest period without a bowel movement more than 7 days
   d. Enemas or laxatives (not fiber or bulk) more than once per month

2. Do you ever have uncontrolled loss of stool?
   Yes                       No

   If yes, how often?
Medical History

3. Circle any of the following problems you have experienced (or are experiencing) and the date of their occurrence.

   a. Bladder tumor
   b. Pelvic irradiation
   c. Recurrent urinary tract infections
   d. Kidney stones
For Women Only

1. How many children have you had?
   - Number of vaginal deliveries
   - Weight of largest baby

2. Have you ever gone through menopause?
   - Yes
   - No
   - If yes, at what age?

3. Do you use estrogens?
   - Yes
   - No
   - If yes, when did you start (month/year)?

4. Are the estrogens…?
   - Oral
   - Cream
   - Both

5. Is there a history of breast cancer in your family?
   - Yes
   - No

6. Have you had a bladder suspension?
   - Yes
   - No
   - If yes, when was it done (month/year)?
For Women Only, continued,

7. Have you ever had a urethral stricture or dilation?  
   Yes  No
   
   If yes, when was it done (month/year)?
   
   8. Have you had a hysterectomy?  
   Yes  No
   
   If yes, when was it done (month/year)?
   
   Vaginal or abdominal?

9. Have you had your ovaries removed?  
   Yes  No
   
   If yes, when was it done (month/year)?
   
Thank you for your help. When you come for your evaluation, please try not to empty your bladder before the visit. Some of the tests done are more useful when done with a full bladder. Wear a pad if you are concerned about leakage.
For Men Only

1. Have you had prostate surgery?
   Yes  No

   If yes, explain what kind and when was it done (month/year)?

   _______________________________________
   _______________________________________
   _______________________________________

2. Have you ever had retention (unable to empty your bladder)?
   Yes  No

3. Have you been told your prostate is enlarged?
   Yes  No

4. Have you had prostate cancer?
   Yes  No

5. Have you ever had prostate infections?
   Yes  No

Thank you for your help. When you come for your evaluation, please try not to empty your bladder before the visit. Some of the tests done are more useful when done with a full bladder. Wear a pad if you are concerned about leakage.