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.

Surgery	**Medications**
Pelvic muscle exercises	**Electrical stimulation**
Bladder training	**Other?** _____
	_____

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 have 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.