

## INCONTINENCE QUESTIONNAIRE

NAME \_\_\_\_\_  
CHART# \_\_\_\_\_

1. How long have you been leaking urine? \_\_\_\_\_
2. Do you wear a pad or other protection every day?    **Yes**                      **No**
  - A. If yes, how many do you typically use per day \_\_\_\_\_ what kind do you use? \_\_\_\_\_
  - B. Are your pads usually **SOAKED** or **DAMP** when you change them? (Circle One Or Both)
3. Do you sometimes experience a sudden strong compelling urge to urinate?    **Yes**                      **No**
4. Can you overcome the sense of urgency to urinate?                      **Never**                      **Occasionally**                      **Usually**
5. Do you ever leak because you can't make it to the bathroom in time?    **Rarely**                      **Occasionally**                      **Frequently**

How often does this occur: \_\_\_\_\_ times per day (or) \_\_\_\_\_ times per week (or) \_\_\_\_\_ times per month?
6. Does the sight, sound, or feel of running water:
  - A. Cause you to feel an urgent need to urinate?    **Yes**    **No**
  - B. Cause you to leak urine?                      **Yes**    **No**
7. Does the urge to urinate wake you up?                      **Never**                      **Occasionally**                      **Frequently**
8. After going to bed, how many times do you usually get up to urinate? \_\_\_\_\_
9. Do you ever leak with the following (Circle All Appropriate):

Cough                      Lifting                      Standing Up

Sneeze                      Laughing                      Exercising (What Kind) \_\_\_\_\_

Straining                      During Sex

  - A. How often does it occur: \_\_\_\_\_ times per day (or) \_\_\_\_\_ times per week (or) \_\_\_\_\_ times per month.
  - B. Does leakage occur **IMMEDIATELY** or several seconds **AFTER** a cough, sneeze, etc. (Circle one).
  - C. In what positions does leakage occur with the above (Circle Any):

Sitting                      Standing                      Laying Down
  - D. Is the amount of leakage **SMALL** or **LARGE**? (Circle one)

10. What percentage of your episodes of urinary leakage:
- A. Are a result of coughing, sneezing, etc. \_\_\_\_\_
- B. Are a result of not making it to the bathroom in time \_\_\_\_\_
- (A + B should add up to 100%).
11. Are you ever wet without knowing when or why you leaked?      **Yes**      **No**
12. Do you frequently limit your fluid intake when you are away from home so that you won't have to worry about finding a restroom?      **Yes**      **No**
13. When you are in a new place, do you make sure you know where the restroom is?      **Never**      **Sometimes**      **Always**
14. Do you avoid places if you think there won't be a restroom nearby?      **Rarely**      **Sometimes**      **Always**
15. What activities do you avoid because of your leakage? \_\_\_\_\_  
\_\_\_\_\_
16. How does your leakage affect your quality of life? Do you feel your problem is (circle one)  
**Mild**      **Moderate**      **Severe**      **Debilitating?**
17. What medications have you tried to control your bladder? \_\_\_\_\_
18. Have you tried pessaries or tampons to control your bladder?      **Yes**      **No**
19. Have you tried Kegel exercises?      **Yes**      **No**
20. Do you ever experience incontinence of gas or stool?      **Yes**      **No**
- If yes, how often?** \_\_\_\_\_  
\_\_\_\_\_

21. When you urinate:

Is the volume of urine you usually pass: **Large** **Average** **Small**

Do you usually have difficulty starting your urine stream? **Yes** **No**

Do you notice any dribbling of urine when you stand after urinating? **Yes** **No**

Do you feel that you have trouble completely emptying your bladder? **Yes** **No**

Have you ever passed bloody urine? **Yes** **No**

Do you have pain during urination? **Yes** **No**

Does it take a long time to empty your bladder? **Yes** **No**

22. Have you ever passed gravel, sand or stones while urinating? **Yes** **No**

23. Have you ever been treated for multiple sclerosis, diabetes, or stroke? **Yes** **No**

24. Did you have urinary problems as a child (e.g., bed wetting)? **Yes** **No**

25. Have you ever had a tube placed in your bladder because you couldn't void? **Yes** **No**

26. Have you had an operation on your spine, brain or bladder? **Yes** **No**

**If yes, please provide the date and details.** \_\_\_\_\_

\_\_\_\_\_

27. Please list your medications \_\_\_\_\_

## POTENTIAL BLADDER IRRITANTS

Estimate how much of the following you consume per day:

Alcoholic beverages	_____	Rarely	Never
Apples and apple juice	_____	Rarely	Never
Black pepper	_____	Rarely	Never
Cantaloupe	_____	Rarely	Never
Carbonated beverages	_____	Rarely	Never
Chili and spicy foods	_____	Rarely	Never
Citrus fruits and citrus juice	_____	Rarely	Never
Chocolate	_____	Rarely	Never
Coffee (including decaffeinated)	_____	Rarely	Never
Cranberries and cranberry juice	_____	Rarely	Never
Grapes and grape juice	_____	Rarely	Never
Nutrasweet drinks	_____	Rarely	Never
Pineapple and pineapple juice	_____	Rarely	Never
Saccharin	_____	Rarely	Never
Strawberries	_____	Rarely	Never
Tea (except caffeine-free herbal tea)	_____	Rarely	Never
Tomatoes and tomato juice or sauce	_____	Rarely	Never
Vinegar	_____	Rarely	Never

What is your occupation? \_\_\_\_\_

Does your job require heavy lifting? \_\_\_\_\_