Urinary Incontinence Questionnaire

1. How often do you urinate during the day?

_____

2. How often do you get up at night to urinate?

_____

3. Is the amount of urine you usually pass...
   ○ Large ○ Average ○ Small

4. Do you usually have a strong sense of urgency to urinate?
   ○ No ○ Yes

5. Do you have to hurry to empty your bladder when full?
   ○ No ○ Yes

6. Are there times when you don't make it to the bathroom and leak urine?
   ○ No ○ Yes

7. Can you overcome the sensation of the urgency to urinate?
   ○ No ○ Yes

8. Does the sight, sound, or feel of running water cause you to lose urine?
   ○ No ○ Yes

9. Do you ever lose urine when lying down?
   ○ No ○ Yes

10. Do you experience any sensations before losing urine?
    ○ No ○ Yes

11. When urinating, can you usually stop your stream?
    ○ No ○ Yes

12. Do you ever accidentally wet the bed while sleeping?
    ○ No ○ Yes

13. Do you have difficulty starting your urine stream?
    ○ No ○ Yes

14. Do you feel that you have completely emptied your bladder after urinating?
    ○ No ○ Yes

15. Do you dribble urine after voiding?
○ No ○ Yes

16. Were you ever catheterized because you were unable to void?
○ No ○ Yes

17. Have you ever had your urethra dilated or stretched?
○ No ○ Yes

18. Do you ever pass blood in your urine?
○ No ○ Yes

19. Have you ever passed sand, gravel, or stones?
○ No ○ Yes

20. Do you have pain during urination?
○ No ○ Yes

21. Have you been treated for three or more urinary infections?
○ No ○ Yes

22. Have you been treated for a bladder infection within six months?
○ No ○ Yes

23. Do you leak urine while coughing, sneezing, laughing, lifting, jumping, or running?
○ No ○ Yes

24. Do you find it necessary to use some type of leakage protection?
○ No ○ Yes

25. Did your urinary difficulty begin:
- During a pregnancy? ○ No ○ Yes
- Following a delivery? ○ No ○ Yes
- Following an abdominal or vaginal operation? ○ No ○ Yes
- After menopause? ○ No ○ Yes
- Other? Please explain:

_____
_____

10. List all medications you have taken in the past six months. Circle those medications you are
presently taking.

_____
_____
_____