

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.
