



Patient Name: _____ Age: _____
 Diagnosis: _____
 Physician: _____ Date of Eval: _____

WOMEN'S HEALTH INCONTINENCE SYMPTOM QUESTIONNAIRE

Describe the reason for your appointment: _____

When did this problem begin? _____ Is it getting: better worse same

List activities or things that you cannot do because of this problem: _____

1. Bladder leakage frequency – number (#) of episodes

- Never
- Only with strong cough/sneeze
- Only premenstrual
- _____ # per month
- _____ # per week
- _____ # per day
- Constant leakage

2. Severity of Leakage (circle one).

- No leakage
- Few drops
- Wets underwear
- Wets outerwear

Range: _____ X / day / week

3. Protection worn

- None
- Tissue paper / Paper towel
- Pantishields
- Minipads
- Maxipad
- Specialty product name _____
- Diaper

Range: _____ / day

4. Leakage caused or increased by (circle all that apply)

- Vigorous activity or exercise (running, weight lifting)
- Light activity (walking, light housework)
- Changing positions (sit to stand)
- Walking to the toilet
- Strong urge to go
- Intercourse or sexual activity
- No activity changes leakage (constant despite activity)
- Other (please list) _____

Parkview Adventist Medical Center
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RSD213-0407 (08-03-07)

PATIENT IDENTIFICATION



THIS FORM IS A MEDICAL RECORD

WOMEN'S HEALTH INCONTINENCE SYMPTOM QUESTIONNAIRE

5. Position or activity with leakage. (circle all that apply)
Lying down
Sitting
Standing
6. How long can you delay the need to urinate?
Not at all
1-2 minutes
3-10 minutes
11-30 minutes
31-60 minutes
_____ hours
7. Rate a feeling of "falling out" or pelvic heaviness/pressure
None present
_____ times per month
Only with menstruation
With standing
With exertion or straining
At the end of each day
Present all day
8. Fluid intake (one glass is 8 oz or one cup)
Total glasses per day _____
of caffeinated glasses _____ per day
of alcoholic beverages _____ per day
of plain water _____ per day
9. Rate your feelings as to the severity of this problem from 0-10 with 10 being the worst
0 _____ 10
not a problem major problem
10. Rate the following statement as it applies to you today:
My bladder is controlling my life
0 _____ 10
not true at all completely true



WOMEN'S HEALTH INCONTINENCE SYMPTOM QUESTIONNAIRE

Bladder Habits

1. How often do you urinate during the day? _____ # of times
 2. How often do you urinate after going to bed? _____ # of times
 3. Do you take your time to go to the toilet and empty your bladder? Yes No
 4. Number of bladder infections in the last year? _____
 5. Can you stop the flow of urine when on the toilet? Yes No
 6. Is the volume of urine passed usually: Large Average Small Very Small
 7. Do you have the sensation that you need to go to the toilet? Yes No
 8. Do you strain to pass urine? Yes No
 9. Do you empty your bladder frequently, before you experience the urge to pass urine? Yes No
 10. Do you have the feeling your bladder is still full after urinating? Yes No
 11. Do you have a slow or hesitant urinary stream? Yes No
 12. Do you have difficulty initiating the urine stream? Yes No
 13. Do you have "triggers" that make you feel like you can't wait to go to the toilet? (running water, etc) Yes No
- Please List _____

Bowel Habits

1. Frequency of bowel movements _____ per day _____ per week
2. Consistency of stool: loose _____ normal _____ hard _____
3. History of constipation? Yes No
4. Do you currently strain to go? Yes No
5. Do you ignore the urge to defecate? Yes No
6. Do you have trouble making it to the toilet in time when you have an urge to go? Yes No



R S D 2 1 3