Bladder Symptom Questionnaire

Name: _______________________________ Date: _____________

Doctor: _______________________________

Which symptoms best describe you? Check all that apply.

☐ Frequent urination—day, night, or both
☐ Sudden or strong urge to urinate
☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
☐ Bladder or pelvic pain
☐ Problems with bowel function (if checked, please select symptom below)
   ☐ Accidental loss or leakage of stool  ☐ Constipation  ☐ Other
☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? ________________________________

Have you tried medications to help your bladder symptoms?  □ Yes  □ No

If yes, how many different medications have you tried? ________________________________

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

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**No Relief**  **Complete Symptom Relief**

Are you still taking any of these medications?  □ Yes  □ No

If no, why have you stopped taking them?

☐ Did not work as well as expected  ☐ Side effects  ☐ Expense
☐ Interaction with other medications  ☐ Other

If Side effects or Other checked, please explain:

__________________________________________________________

Behavior modifications tried?
(i.e., reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number.

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**Not Frustrated**  **Extremely Frustrated**

Are you interested in learning more about additional treatment alternatives to bladder medications?  □ Yes  □ No