SWEDISH
MEDICAL GROUP

Bladder Control Questionnaire

Please answer the following questions to the best of your ability:

How many pregnancies have you had: __________

How many live births: ______________________

Were your babies delivered vaginally or by C-section: ______________________

On an average day, how frequently do you use the bathroom to urinate from the time you wake up until bed time: ______________________

How many times do you wake at night to urinate: ______________________

Do you ever urinate unintentionally while you are asleep: ☐ Yes ☐ No

If you cough or sneeze or jump or run or perform strenuous activity, do you leak urine: ☐ Yes ☐ No

Do you ever feel the urge to urinate suddenly where you need to get to the bathroom quickly: ☐ Yes ☐ No

Do you ever leak urine before you have a chance to make it to the bathroom: ☐ Yes ☐ No

Do you ever leak urine without any sensation or awareness that you have leaked: ☐ Yes ☐ No

Do you wear a pad or diaper for protection and, if so, how many do you go through in 24 hours: ______________________

When you urinate, do you have to strain to initiate the stream: ☐ Yes ☐ No

Is the stream:
☐ Normal ☐ Strong ☐ Weak ☐ Dribble ☐ Varies

Do you feel that you are empty when you finish urinating and leave the bathroom: ☐ Yes ☐ No

Does it hurt or burn when you urinate:
☐ Yes ☐ No

Do you ever see blood in your urine: ☐ Yes ☐ No

Have you ever had a urinary tract infection and, if so, how many do you average in a year: __________

Have you ever had a kidney infection: ☐ Yes ☐ No

Have you ever had a kidney stone: ☐ Yes ☐ No

Have you ever had surgery on your urinary tract and, if so, what was it and when: ______________________

Have you ever been unable to urinate (unrelated to surgery or hospitalization) where you had to wear a catheter for any extended period of time (urinary retention): ☐ Yes ☐ No

How much liquid do you typically drink in 24 hours (total of everything): ______________________

How much caffeine do you typically drink in 24 hours: ______________________

How much alcohol do you typically drink in 24 hours: ______________________

Do you have regular menstrual cycles:
☐ Yes ☐ No

Have you had a hysterectomy: ☐ Yes ☐ No

Do you still have your ovaries: ☐ Yes ☐ No

Have you had normal PAP smears: ☐ Yes ☐ No

Have you had normal mammograms: ☐ Yes ☐ No

Do you use any hormones (birth control pills, patches, IUD, topical estrogen creams):
☐ Yes ☐ No

Are your bowel movements:
☐ Regular ☐ Constipated ☐ Loose ☐ Variable

Do you notice blood in your stools: ☐ Yes ☐ No

Do you ever find the stool becomes trapped where you have to use your finger to manually remove it:
☐ Yes ☐ No

Have you had a colonoscopy and, if so, was it normal: ______________________

Do you feel a bulge or that something is falling or prolapsing out of the vagina: ☐ Yes ☐ No

Are you sexually active: ☐ Yes ☐ No

What factors, if any, make your symptoms better: ______________________

What factors, if any, make your symptoms worse: ______________________

What treatments have you had in the past for your symptoms: ______________________

What is your most bothersome voiding symptom: ______________________

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY:711)

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-313-9127 (Swedish Edmonds 888-311-9178) (TTY:711)

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