Fox Valley
WOMEN & CHILDREN'S
HEALTH PARTNERS
committed to providing full circle quality care

Name: ____ DOB___/___/____

What is the reason for this visit? Incontinence Pain Prolapse

Have you had previous treatments for this problem? Yes No

Previous treatments include: Medication Physical Therapy Surgery
Dates and treatment:

____

Please list the names of other physicians you have seen for this problem:

____

Urinary Function Questionnaire:

Do you have to empty your bladder frequently?	NO	YES
How Often Every Hour	Every 1-2 hours	Every 2-3 hours
Does the sound or sight of running water cause you to lose urine?	NO	YES
If your bladder is full, do you have to run to the nearest bathroom?	NO	YES
Do you ever leak urine when trying to reach the bathroom?	NO	YES
Amount: SMALL LARGE	AVERAGE	VARIES
Do you get up during the night to urinate?	NO	YES
Do you lose urine when resting (just lying or sitting)	NO	YES
Do you lose urine during sexual activity?	NO	YES
Do you have pain with sexual intercourse?	NO	YES
Do you lose urine without being aware it is passing?	NO	YES
Do you lose urine during coughing, sneezing, laughing or lifting?	NO	YES
Do you lose urine when you are walking?	NO	YES
Do you lose urine if you suddenly stand up from a sitting position?	NO	YES
When you are urinating, can you usually stop the flow?	NO	YES
Do you have the feeling your bladder is not empty after you urinate?	NO	YES
Do you have to strain or push to empty your bladder?	NO	YES
Is it usually painful or difficult to pass your urine?	NO	YES
Do you have pain when your bladder is full?	NO	YES
Do you have burning during or after urination?	NO	YES

Fox Valley WOMEN & CHILDREN'S HEALTH PARTNERS
committed to providing full circle quality care

Have you had multiple urinary tract infections?	NO	YES
Is you urine ever bloody?	NO	YES
Do you have pain with bowel movements?	NO	YES
Do you have a problem controlling bowel movements?	NO	YES
Do you have a problem controlling gas from the rectum?	NO	YES
Do you have a problem with constipation?	NO	YES
Do you find it necessary to wear protection because you get wet?	NO	YES

Quality of Life Questionnaire

Has urine leakage or prolapse affected the following:	Not at all	Slightly	Moderately	Greatly
Ability to do chores such as cooking, cleaning, or laundry?	Not at all	Slightly	Moderately	Greatly
Activities such as walking, swimming or other exercise?	Not at all	Slightly	Moderately	Greatly
Entertainment (movies, concerts, etc)?	Not at all	Slightly	Moderately	Greatly
Ability to travel by car or bus?	Not at all	Slightly	Moderately	Greatly
Social activities outside your home?	Not at all	Slightly	Moderately	Greatly
Emotional health (nervousness, depression)?	Not at all	Slightly	Moderately	Greatly
How much are you bothered by the following?				
Feeling frustrated?	Not at all	Slightly	Moderately	Greatly
Frequent urination?	Not at all	Slightly	Moderately	Greatly
Urine leakage with physical activity, coughs, or sneezes?	Not at all	Slightly	Moderately	Greatly
Small amounts of urine leakage (drops)?	Not at all	Slightly	Moderately	Greatly
Difficulty emptying your bladder?	Not at all	Slightly	Moderately	Greatly
Pain in the lower abdominal or genital area?	Not at all	Slightly	Moderately	Greatly

ALLERGIES

NO KNOWN DRUG ALLERGIES

LATEX BETADINE

Other________________________