Robert D. Mayer, M.D.
University of Rochester Medical Center
Department of Urology

*Date:*_____

NAME:_____DATE OF BIRTH:_____

INITIAL HISTORY QUESTIONNAIRE FOR INCONTINENCE

1. How long a period of time have you been bothered by your urinary leakage?
   _____0 to 6 months _____2-5 years
   _____6 to 12 months _____5-10 years
   _____1-2 years _____> 10 years

2. Frequency of incontinence: How often has your loss happened on an average in the last three months?
   _____< Once a month _____2-4 times a day
   _____< Once a week _____5-10 times a day
   _____1-6 times a week _____> 10 times a day
   _____About once a day

3. At the present time, are you coping with the leakage by wearing pads? _____Yes _____No

4. If so, please estimate the frequency of pad use:
   _____0-1 pad/day, _____or per week
   _____1-2 pads/day, _____or per week
   _____2-4 pads/day, _____or per week
   _____4-6 pads/day, _____or per week
   _____7-10 pads/day, _____or per week
   _____More than 10 pads/day, _____or per week

5. Type of pads used: _____Tissue paper
   _____Light liners
   _____Medium pants
   _____Heavy pants
   _____Adult diapers

6. How much urine do you usually leak? Are your pads, pants or sheets usually:
   _____dry _____damp _____wet _____soaked

7. Do you need to change your clothing during the day because of urine leakage?
   _____Yes _____No

   If yes, what is the average number of clothes changes each day due to urine leakage?_____

8. Do you use a special pad at night to protect the bed linens? _____Yes _____No

9. How often do you lose your urine during your sleeping hours?
   _____Never _____Rarely _____Sometimes _____Often

10. What time of day do the accidents most frequently occur?

_____Morning _____Same throughout day
_____Afternoon _____While sleeping
_____Evening

11. Did your incontinence become worse or more severe after a particular event?

_____Childbirth _____No sudden change/gradual problem
_____Surgery _____Other (see below)
_____Stroke

We would like to know which activities cause you to leak urine. Please indicate the frequency with which the following activities are associated with urine loss.

Vigorous activity such as straining, coughing or sneezing, jogging or heavy lifting or strenuous exercise:

_____Always _____Rarely
_____Often _____Never
_____Sometimes

Moderate activity such as climbing stairs, getting up from chair, bending over, lifting routine household items:

_____Always _____Rarely
_____Often _____Never
_____Sometimes

Minimal activity such as walking, turning, twisting:

_____Always _____Rarely
_____Often _____Never
_____Sometimes

12. Do you feel a strong urge to empty your bladder prior to leaking urine? _____Yes _____No

13. If you can't find a toilet and you have the urge to urinate do you end up losing urine?

_____Always _____Rarely
_____Often _____Never
_____Sometimes

14. Please check which events seem to most provoke a strong sense of urgency to urinate:

_____Washing dishes or taking a shower
_____Change of position from sitting or standing
_____Placing key in lock to enter home or office
_____Coughing or sneezing

15. If you are aware that your bladder is full, how long can you hold your urine?

_____Unable to hold _____about 5-10 minutes
_____< 1-5 minutes _____as long as desired

16. When you leak urine, is the incontinence usually associated with a sudden urge that cannot be controlled or is the leakage more often associated with activities such as coughing, but without an uncontrollable sense of sudden urgency?
_____Usually with sensation of sudden urgency to void
_____Usually with activities such as coughing or straining, but without a strong sense of sudden urgency
_____About the same of each type
_____Unable to determine

17. How many times do you go to the toilet in a usual day?
_____2-4 times/day _____11-14 times/day
_____5-7 times/day _____> 15 times/day
_____7-10 times/day

18. How many times do you usually go to the toilet **during your sleeping hours**?
_____None _____4-5
_____0-1 _____> 6
_____2-3

19. Have you had chronic problems with frequent urination and urgency?_____Yes _____No

Bladder Sensation and Emptying Symptoms

20. Are you usually aware when you are leaking urine? _____Yes _____No

21. Are you able to tell when your bladder is full? _____Yes _____No

22. Do you have pain over the bladder when full? _____Yes _____No

23. Do you have pain or burning when passing urine?_____Yes _____No

24. After urinating do you have the sense of not emptying completely?_____Yes _____No

25. Have you required using a catheter to empty your bladder? _____Yes _____No

26. If currently using a catheter, how many times a day is it used?
_____Only as needed _____3-4/day
_____1/day _____>4/day
_____2-3/day

27. Do you have to strain or make an unusual effort to urinate or have difficulty starting your stream?
_____Yes _____No

28. Does your stream start and stop while trying to void? _____Yes _____No

29. Do you have to stand or use an awkward position to urinate? _____Yes _____No

30. Have you lost control of your bowel movements? _____Yes _____No

31. If so, how often does this occur?_____Less than once a week _____Greater than once a week

32. Do you have any problems with constipation? _____Yes _____No

33. Do you have any problems with diarrhea? _____Yes _____No

34. Are you sexually active? _____Yes _____No

35. Do you ever lose urine during intercourse? _____Yes _____No

36. Do you have any pain or discomfort during intercourse? _____Yes _____No

37. Do you have any skin redness or soreness associated with leaking urine? _____Yes _____No

38. How many glasses of fluids a day do you drink?
_____0-2 glasses _____7-10 glasses
_____3-6 glasses _____>10 glasses

39. How many cups or glasses of beverages such as coffee/tea/Coke do you drink each day?
_____None _____4-6 glasses/cups
_____1-2 glasses/cups _____> 6 glasses/cups
_____2-4 glasses/cups

40. If so, are these _____regular, _____decaffeinated, or _____caffeine free?

41. How many glasses of alcoholic beverages such as wine/beer/cocktails do you drink each day?
_____None _____2-4 glasses
_____Occasionally _____4-6 glasses
_____1-2 glasses

42. Are you taking water pills at present for weight loss, high blood pressure, edema or heart disease?
_____Yes _____No

43. Have you had problems with frequent urinary tract infections? _____Yes _____No

44. Do you have a history of any of the following diseases, which could interfere with your voiding?
_____Stroke
_____Slipped disc with leg weakness or numbness
_____Diabetic neuropathy
_____Multiple sclerosis
_____Parkinson's disease

45. Are toilets conveniently located for you at home? _____Yes _____No
at work? _____Yes _____No

46. Do you have physical disabilities such as arthritis or weakness that impairs your ability to get to the toilet? _____Yes _____No

47. Do you have any breathing problems such as allergies or sinus trouble that causes you to cough frequently? _____Yes _____No

48. How many pregnancies have you had?_____
How many vaginal deliveries have you had?_____
How many C-sections have you had?_____
How many miscarriages/abortions have you had?_____

49. Did you experience urine loss during or just after any of your pregnancies?_____Yes _____No

50. What was the approximate weight of your largest child delivered vaginally?_____

51. Are you still having periods? _____Yes _____No
When was your last menstrual period? _____

52. Have you had a hysterectomy? _____Yes _____No
Approximately what year?_____
Was the surgery for: _____NA
_____Cancer
_____Bleeding
_____Pain/fibroids
Were the ovaries removed? _____Yes _____No

53. Have you ever had any previous evaluation and treatment for your incontinence?
_____Yes _____No

54. What diagnostic tests were performed?
_____None
_____Catheter to drain the bladder
_____Catheter to fill the bladder and measure pressures (cystometrogram)
_____X-rays of the bladder
_____Looking in the bladder with a endoscope (cystoscopy)

55. Have you previously tried pelvic floor exercises (Kegel) to control your incontinence?
_____Yes _____No

56. How were the exercises taught?
_____Written/verbal instructions
_____Training sessions with nurse during vaginal exam
_____Biofeedback/electrical instructions
_____Cone devices

57. If you had this treatment, what is your opinion regarding the results of these exercises?
_____Worse _____Moderate improvement
_____No improvement _____Great improvement (dry)
_____Mild improvement

58. Have you tried any of the following medications to control your urine loss?
_____Ditropan (oxybutynin) _____Pro Banthine (Propantheline)
_____Detrol (tolterodine) _____Tofranil (imipramine)
_____Levsin/Urispas (hyoscyamine)

59. If you had this treatment, what is your opinion regarding the results of these medications?

_____Worse _____Moderate improvement
_____No improvement _____Great improvement (dry)
_____Mild improvement

60. Have you had any surgery to control your urine loss? _____Yes _____No

If yes, what kind of surgery and date?

_____Bladder lifting through abdomen _____(date)
_____Bladder lifting through vagina _____(date)
_____Sling or strap procedure _____(date)
_____Collagen injection _____(date)
_____Other (fill in details below)

_____

_____

61. If you had surgery, what is your opinion regarding the results?

_____Worse _____Moderate improvement
_____No improvement _____Great improvement (dry)
_____Mild improvement

62. How long did this effect last?_____