

Bladder Health Questionnaire

1. How often do you urinate during the day? _____

2. How often do you get up at night to urinate? _____

3. Is the amount of urine you usually pass... ☐ Large ☐ Average ☐ Small

4. Do you usually have a strong sense of urgency to urinate? ☐ No ☐ Yes

- Do you have to hurry to empty your bladder when full? ☐ No ☐ Yes

- Are there times when you don't make it to the bathroom and leak urine? ☐ No ☐ Yes

- Can you overcome the sensation of the urgency to urinate? ☐ No ☐ Yes

- Does the sight, sound, or feel of running water cause you to lose urine? ☐ No ☐ Yes

- Do you ever lose urine when lying down? ☐ No ☐ Yes

- Do you experience any sensations before losing urine? ☐ No ☐ Yes

- When urinating, can you usually stop your stream? ☐ No ☐ Yes

- Do you ever accidentally wet the bed while sleeping? ☐ No ☐ Yes

5. Do you have difficulty starting your urine stream? ☐ No ☐ Yes

- Do you feel that you have completely emptied your bladder after urinating? ☐ No ☐ Yes

- Do you dribble urine after voiding? ☐ No ☐ Yes

6. Were you ever catheterized because you were unable to void? ☐ No ☐ Yes

- Have you ever had your urethra dilated or stretched? ☐ No ☐ Yes

- Do you ever pass blood in your urine? ☐ No ☐ Yes

- Have you ever passed sand, gravel, or stones? ☐ No ☐ Yes

- Do you have pain during urination? ☐ No ☐ Yes

7. Have you been treated for three or more urinary infections? ☐ No ☐ Yes

- Have you been treated for an infection within six months? ☐ No ☐ Yes

8. Do you lose urine while coughing, sneezing,
laughing, lifting, jumping, or running?

☐ No ☐ Yes

- Do you find it necessary to use some type of protection?

☐ No ☐ Yes

9. Did your urinary difficulty begin:

- During a pregnancy?

☐ No ☐ Yes

- Following a delivery?

☐ No ☐ Yes

- Following an abdominal or vaginal operation?

☐ No ☐ Yes

- After menopause?

☐ No ☐ Yes

- Other? Please explain: _____

10. List all medications you have taken in the past six months. Circle those medications you are
presently taking.
