FEMALE UROLOGY QUESTIONNAIRE

Circle Yes or No

Leaking with cough, laugh, or exercise (stress incontinence)?  Y  N
Leaking with urgency (can’t get to toilet in time/leak with running water)  Y  N
Which is worse? (circle one) Stress leaks  Urge leaks  They are both equally bothersome
How many pads in 24 hours?  None, 1, 2, 3, 4, 5, 6, 7+  type ______________
Do you have any fecal/stool leakage?  Y  N

How many urinations per day?  <4,  5 - 8,  9 - 12,  12+

How many times do you get up at night to urinate?  _______
How many cups of caffeinated beverages per day?  ______ cups/day

Any Pain with urination  Y  N
Any other bladder issues or pain in Pelvis to describe? ___________________________________________
_______________________________________________________________________________________

Any pushing or straining to urinate?  Y  N
Have to push on vaginal bulge to start or complete urination  Y  N
Bulge or something you see or feel falling out of the vaginal area  Y  N
Have to push on the vagina or around the rectum to have or complete a bowel movement  Y  N

Any prior surgeries of the pelvis, bladder or uterus? ______________________________________________
________________________________________________________________________________________

Have you seen a Pelvic Floor Physical Therapist?  Whom? _______________________________________
What medications OR SURGERIES have you tried to address your bladder symptoms? Did they work?

_______________________________________________________________________________________
_______________________________________________________________________________________

SEXUAL WELLNESS – only fill out if it applies to you

Are you sexually active?

Yes ------ What are your goals for improvement? ________________________________

_______________________________________________________________________________________

No ------ If you wish to be what are your barriers for improvement? ___________________

_______________________________________________________________________________________

Lubrications used_______________________________________________________________

Vaginal Estrogen/Testosterone/DHEA/lasers used:_________________________________________

Physical Therapists AND Sex therapists seen for this condition:_____________________________

Low desire: What factors are contributing to your decrease in desire? Please explain

Medical condition:_______________________________________________________________

Medication Side effects:___________________________________________________________

Pregnancy, childbirth, breastfeeding, menopause:_____________________________________

PAIN:___________________________________________________________________________

Your Partner sexual problems or your relationship:_____________________________________

Stress or Fatigue:_________________________________________________________________