Today's Date:

In an effort to provide the best experience during your office visit today and to help us keep current on your health, please take a few minutes to complete the following questions.

Thank vou!

Name: _____ DOB:_____

Phone #:_____ Mobile#:_____

Email:_____

Primary Care Provider:_____ Phone: _____

Notes:

Grade Your Bladder Health

1. Do you leak urine (even small drops) with laughing, coughing, sneezing, exercising or lifting heavy objects?..... **YES NO**

2. Do you leak urine when you feel the need to empty your bladder, but can't get to the toilet fast enough?..... **YES NO**

3. Do you wear protective undergarments "just in case" ?
If YES, How Many per Day?_____ ..... **YES NO**

4. Do you ever feel that you can't completely empty your bladder?..... **YES NO**

5. Do you ever experience pain during or after emptying your bladder? ..... **YES NO**

6. Have you had 3 or more bladder infections (UTIs) in the past 6 months? ..... **YES NO**

7. How many times do you get up at night to urinate?
time (s) per night ..... **___/night**

8. Are you interested in learning more about a conservative "cure" that does not involve surgery or medications?..... **YES NO**

FOR OFFICE USE ONLY:

Refer to PFR? ***YES*** ***NO***

Provider: _____