Auburn Urogynecology and Women's Health

Urogynecologic Symptom Questionnaire

Do you leak urine?		Yes	No
Do you wear pads for urine leakage protection?		Yes	No
If so, how many pads per day?			
When you change your pads, are they?	Dry	Damp	Wet
Do you leak urine in spurts when laughing, coughing, sneezing, or upon exertion?		Yes	No
Do you have a severe sense of urgency before leaking urine?		Yes	No
Do you experience urine leakage without knowing it?		Yes	No
Does the sound, sight, or feel of running water cause you to lose urine?		Yes	No
Do you wet your bed at night?		Yes	No
Is it painful to pass or leak urine?		Yes	No
Do you feel that you are able to empty your bladder completely when you sit down to urinate?		Yes	No
Is it difficult to get the urine stream started?		Yes	No
Does your urine stream seem weak or slow?		Yes	No
Do you feel as if your pelvic organs are falling down or can you feel a bulge at the opening of your vagina?		Yes	No
Have you ever had blood in your urine?		Yes	No
Do you have frequent urinary tract infections?		Yes	No
How long have you been experiencing the above problems?			
During an average day, I urinate _____ times/day. I usually urinate every _____hours during the day. At night, I get up _____times to urinate.			
I move my bowels _____times/day and _____times/week.			
Do you experience loss of stool?		Yes	No
Do you have blood in your stools?		Yes	No
Do you experience regular bowel movements?		Yes	No
Do you experience difficulty emptying your rectum?		Yes	No
Do you have to strain during a regular bowel movement?		Yes	No
Do you feel pressure in your vaginal region?		Yes	No
Do you have to manually push stool out?		Yes	No
Please list any previous tests or treatments you've had for either urinary or bowel symptoms?			
Was the treatment successful? Explain.			
What is your daily fluid intake? #cups of fluid/day_____ #cups of caffeine per day (coffee, tea, soda) _____			
Signature:			
Printed name: Date:			