Urodynamic Testing Questionnaire

Patient Name:_____Date:_____

Please circle your answers:

1. Do you lose urine in spurts with coughing, sneezing, or exertion? YES NO
2. What amount of urine do you lose? Small amt. Large amt.
3. In what position do you lose urine? Sitting/standing Lying down Any
4. Do you wear a pad all of the time? YES NO Large pad Mini pad
5. Does the sound, sight, or feel of running water cause you to lose urine? YES NO
6. Do you have a severe sense of urgency before losing urine? YES NO
7. Can you voluntarily stop urine flow? YES NO
8. Do you ever wet the bed during the night? YES NO
9. How many times do you get up to urinate during the night? _____
10. Do you lose urine as a constant drip from the vagina? YES NO
11. Is it painful or crampy to pass or lose urine? YES NO
12. Do you have problems with gas or bowel movement control? YES NO
13. What is your daily caffeine intake? _____oz.

Comments:_____

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