AWARE WOMEN'S HEALTH

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Urinary Incontinence Questionnaire

Please complete this form and return it to the rooms prior to, or at the time of your consultation.

NAME AND CONTACT DETAILS

Name:

Date of birth:

Number of pregnancies:

Number of children:

Weight of heaviest child:

SYMPTOMS

How long has urinary incontinence troubled you?

Do you currently need to wear pads for protection? Y / N

How many times do you need to go to the toilet:

Times per day: Times per night::

Have you had to limit any activities due to incontinence? Y / N

How many teas/coffees (combined) do you drink per day?

In which situations do you experience incontinence:

- ☐ Coughing/sneezing
- ☐ Exercise
- ☐ Minimal activity (eg. walking)
- ☐ At rest
- ☐ On the way to the toilet
- ☐ At night
- ☐ With intercourse

How many times a day do you experience incontinence?

Are you able to “hold off ” when you need to urinate? Y / N

Do you have difficulty starting to urinate, or do you need to strain to pass urine? Y / N

Does the flow rate of urine seem slow? Y / N

Are you able to stop the flow during urination? Y / N

Do you experience urine dribbling at the end of urinating? Y / N

Do you feel that your bladder empties completely? Y / N

Have you experienced urinary tract infections? Y / N

If yes, how many in the past year?

Do you experience pain with urination? Y / N

Has there ever been blood in your urine? Y / N

Do you have back pain? Y / N

PREVIOUS INVESTIGATIONS AND TREATMENT

What kind of health care provider have you previously seen in relation to this problem:

- ☐ GP
- ☐ Gynaecologist
- ☐ Physiotherapist
- ☐ Alternative therapist, please specify:
- ☐ Other, please specify:

What previous investigations have you had? (Eg. Xrays, ultrasounds, urodynamics)?

What previous treatment have you had, if any:

- ☐ Drug treatment
- ☐ Surgery
- ☐ Plysiotherapy

Did previous treatment help? Y / N