For Women with Poor Bladder Control

1. Do you lose bladder control when you cough, strain, push, or stand?
   Often Occasionally Rarely Never
2. Do you lose bladder control when you get the urge to urinate and can't get to the toileton time?
   Often Occasionally Rarely Never
3. Do you lose bladder control at unpredictable times? **Yes No**
4. Do you wear pads because of poor bladder control? **Yes No**
   If yes, how many times each day do you change the pads? **1 2 3 4 5+**
   Type of pad used? _____
5. How many times do you pass urine each day? **2-4 5-7 8-10 10+**
6. During the night, how many times do you get up to urinate? **0 1 2 3 4 5+**
7. When urinating, do you feel like you empty your bladder? **Yes No**
8. Date bladder symptoms began _____
9. How many 8oz Cups of fluid do you drink in a 24 hour period? **3-5 6-8 9-11 12-14**
   Coffee___cups per day Tea____cups per day Citrus Juices____cups per day
10. How many children have been born to you? _____
    Were the births: **Natural_____ C-Section_____**
11. Have you experienced menopause (change of life)? **Yes No**
12. Do you have poor control of bowel movements? **Yes No**
13. Do you have a serious problem with your neck or back? **Yes No**

Previous Operations

1. Have you had a hysterectomy? **Yes No**
2. Have you had one or both of your ovaries removed? **Yes No**
3. Have you had an operation to lift your bladder (bladder suspension, A&P Repair, etc.)?
   Yes No If yes, please write the year(s)_____
4. Have you ever had an operation on your spine (neck or back)? **Yes No Years_____**

Other Medical Problems

1. Do you have a serious neurological disease such as: Multiple Sclerosis, Parkinsonism, Seizures, Convulsions, or other?
   If yes, please list:_____
2. Do you have an eye disease called Glaucoma? **Yes No**

Medications

1. Please circle any medications you are allergic to:
   Bactrim Septra Sulfa Penicillin Macrodantin None Listed
2. Please circle any listed medications you are currently taking or have taken:
   Ditropan Probantine Tofranil Levsinex Ornade Entex Resaid

Patient Name_____

MR#_____