

Incontinence Patient Information Form

Please complete this form and bring it with you to your next appointment

Before talking with you, your health care provider would like some information about your urine leakage. These questions are important for finding out what is causing the leakage. This will be discussed with you during your visit.

What changes would you like to see in your symptoms as a result of your treatment?

Description of Urine Leakage

1. How long have you had urine leakage?

2. Have you ever been treated for your urine leakage?

3. Circle all treatments that you have received in the past.

Surgery

Medications

Pelvic muscle exercises

Electrical stimulation

Bladder training

Other?

(Adapted with permission from the Practicing Physician Education Project 2006)

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4. Circle all self-help techniques you have tried.

Pads/diapers

Drink less fluids

Go to the toilet often

Stay near a bathroom

5. Other self-help techniques?

6. How often do you leak urine?

7. How much urine do you leak each day?

Activities Leading to Urine Leakage

Please circle how often each of the following activities leads to a loss of urine

1. Changing position from sitting, or standing up

Never

Rarely

Sometimes

Often

Always

Not able

2. Running

Never

Rarely

Sometimes

Often

Always

Not able

3. Sneezing or coughing

Never

Rarely

Sometimes

Often

Always

Not able

4. Laughing

Never

Rarely

Sometimes

Often

Always

Not able

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Fluid Intake and Smoking (cup = 6 oz; glass = 8 oz; mug = 12 oz)

1. Do you drink coffee, tea, or soda products with caffeine?

Yes

No

How much? _____ oz.

2. How many glasses of fluid do you drink each day (including the caffeinated beverages you mentioned above)?

3. How much fluid do you drink in the two hours before you go to bed?

_____ oz.

4. Do you drink alcohol?

Yes

No

If yes, about how much do you drink each day?

(1 drink = 12 oz. beer, 6 oz. wine, 2 oz. hard liquor)

5. Do you smoke cigarettes?

Yes

No

If yes, how many packs do you smoke each day?

How many years have you smoked?

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Bowel Control

1. Circle any of the following problems you have experienced with your bowels.
 - a. Straining on more than one quarter of bowel movements
 - b. Stool frequency less than 3 times per week
 - c. Longest period without a bowel movement more than 7 days
 - d. Enemas or laxatives (not fiber or bulk) more than once per month

2. Do you ever have uncontrolled loss of stool?

Yes

No

If yes, how often?

Medical History

Circle any of the following problems you have experienced (or are experiencing) and the date of their occurrence.

a. Bladder tumor

b. Pelvic irradiation

c. Recurrent urinary tract infections

d. Kidney stones

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Women Only

1. How many children have you had?

Number of vaginal deliveries

Weight of largest baby

2. Have you gone through menopause?

Yes

No

If yes, at what age?

3. Do you use estrogens?

Yes

No

If yes, when did you start (month/year)?

4. Are the estrogens...?

Oral

Cream

Both

5. Is there a history of breast cancer in your family?

Yes

No

6. Have you had a bladder suspension?

Yes

No

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If yes, when was it done (month/year)?

7. Have you ever had a urethral stricture or dilation?

Yes

No

If yes, when was it done (month/year)?

8. Have you had a hysterectomy?

Yes

No

If yes, when was it done (month/year)?

Vaginal or abdominal?

9. Have you had your ovaries removed?

Yes

No

If yes, when was it done (month/year)?

Thank you for completing this form. When you come for your evaluation, please try not to empty your bladder before the visit. Some of the tests done are more useful when done with a full bladder. Wear a pad if you are concerned about leakage.

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For Men Only

1. Have you had prostate surgery?

Yes

No

If yes, explain what kind and when was it done (month/year)?

2. Have you have ever had retention (unable to empty your bladder)?

Yes

No

3. Have you been told your prostate is enlarged?

Yes

No

4. Have you had prostate cancer?

Yes

No

5. Have you ever had prostate infections?

Yes

No

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