# Swedish Urology Group, PC

## Bladder Control Questionnaire

**Please answer the following questions to the best of your ability:**

How many pregnancies have you had: _____
How many live births: _____
Were your babies delivered vaginally or C-section: _____
On an average day, how frequently do you use the bathroom to urinate from the time you wake up until bed time: _____
How many times do you wake at night to urinate: _____
Do you ever urinate unintentionally while you are asleep: _____
If you cough or sneeze or jump or run or perform strenuous activity, do you leak urine: _____
Do you ever feel the urge to urinate suddenly where you need to get to the bathroom quickly: _____
Do you ever leak urine before you have a chance to make it to the bathroom: _____
Do you ever leak urine without any sensation or awareness that you have leaked: _____
Do you wear a pad or diaper for protection, and if so, how many do you go through in 24 hours: _____
When you urinate, do you have to strain to initiate the stream: _____
Is the stream normal, strong, weak, dribble, or does it vary: _____
Do you feel that you are empty when you finish urinating and leave the bathroom: _____
Does it hurt or burn when you urinate: _____
Do you ever see blood in your urine: _____
Do you ever have urinary tract infection, and if so, how many do you average in a year: _____
Have you ever had a kidney infection: _____
Have you ever had a kidney stone: _____
Have you ever had surgery on your urinary tract and if so what was it and when: _____
Have you ever been unable to urinate (unrelated to surgery or hospitalization) where you had to wear a catheter for any extended period of time (urinary retention): _____
How much liquid do you typically drink in 24 hours (total of everything): _____
How much caffeine do you typically drink in 24 hours: _____
How much alcohol do you typically drink in 24 hours: _____
Do you have regular menstrual cycles: _____
Have you had a hysterectomy: _____
Do you still have your ovaries: _____
Have you had normal PAP smears: _____
Have you had normal mammograms: _____
Do you use any hormones (birth control pills, patches, IUD, topical estrogen creams): _____
Are your bowel movements regular/constipated/loose/variable: _____
Do you notice blood in your stools: _____
Do you ever find the stool becomes trapped where you have to use your finger to manually remove it: _____
Have you had a colonoscopy and if so, was it normal: _____
Do you feel a bulge or that something is falling or prolapsing out of the vagina: _____
Are you sexually active: _____
What factors, if any, make your symptoms better: _____
What factors, if any, make your symptoms worse: _____
What treatments have you had in the past for your symptoms: _____
_____
What is your most bothersome voiding symptom: _____
_____