



## FIRST VISIT QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you leak urine when you cough, sneeze or laugh? ..... Yes/No
2. Do you regularly have a strong urge to urinate, such that if you do not reach the bathroom quickly you feel you will leak? ..... Yes/No
3. If yes, do you leak before reaching the bathroom? ..... Yes/No
4. How many times do you get up to urinate during the night? ..... \_\_\_\_\_
5. Have you wet your bed as an adult? ..... Yes/No How often? \_\_\_\_\_
6. How often do you leak? ..... \_\_\_ day/week/month/not sure
7. Do you leak during or after sexual intercourse? ..... Yes/No/NA
8. Do you wear a pad because you are leaking? ..... Yes/No  
If so, how many do you wear ..... per day? \_\_\_\_\_ What type? \_\_\_\_\_
9. Do you have pain when you urinate? ..... Yes/No
10. Have you had any urinary infections in the last year? ..... Yes/No
11. Do you have blood in your urine? ..... Yes/No
12. Do you find it hard to start urinating? ..... Yes/No
13. Do you have a slow urinary stream or have to strain to start urinating? ..... Yes/No
14. After you urinate, do you feel your bladder is still full? ..... Yes/No
15. Do you have glaucoma? ..... Yes/No
16. Do you have a pacemaker or any metal in your body? ..... Yes/No
17. Do you lose stool involuntarily? ..... Yes/No
18. Do you have problems evacuating a bowel movement? ..... Yes/No
19. Have you ever tried any medication for your bladder problem? ..... Yes/No  
If yes, please list what you have tried and if it offered any relief:

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20. Has your incontinence greatly impacted your life? ..... Yes/No  
If yes, how? How does it interfere with your life?

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