PIONEER VALLEY
UROLOGY, P.C.

Female Bladder Health History

Name: _____ Date: _____DOB: _____
Chief Concern: (What are your main symptoms and how long have they occurred?)

Overflow

1. Do you feel that you do not empty your bladder completely?	Yes	No	
2. Do you usually urinate in small amounts?	Yes	No	
3. Do you take a long time to urinate or have a weak stream?	Yes	No	
4. Do you have trouble starting to urinate?	Yes	No	

Frequency/Urgency

1. Do you have a "gotta-go" feeling?	Yes	No	
2. Do you barely make it to the bathroom in time or leak on the way?	Yes	No	
3. Do you feel you go to the bathroom frequently?	Yes	No	
4. Number of times during the day you urinate? _____			
5. Number of times you get up to urinate at night? _____			
6. Do you purposely go to the bathroom more frequently in order to avoid accidents?	Yes	No	
7. Do you plot bladder locations wherever you go?	Yes	No	

Stress Incontinence

1. Do you leak when you cough, sneeze or exercise?	Yes	No	
2. Does getting up from a chair or getting out of bed cause you to leak?	Yes	No	
3. What else may cause you to leak?_____			

Urine Loss

1. Are you always aware of your urine loss?	Yes	No	
2. How often do you leak on an average day? ☐I do not leak ☐1-5 times ☐5-10 times ☐ Continuously			
3. How often do you leak during an average night? ☐I do not leak ☐1-5 times ☐5-10 times ☐ Continuously			
4. When you leak, how much do you usually leak? ____a few drop ____ less than a cup ____more			
5. Do you wear pads or other home remedies? ____During the day ____ During the night ____ Both	Yes	No	
6. How many pads do you use in a day?_____			
7. What kind of pads do you use? _____			

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Related Problems

1. When you urinate, do you have burning or discomfort?	Yes	No	
2. Do you have a history of bladder infections or other bladder problems? *(Such as blood in your urine)*	Yes	No	
3. Do have ever have constipation?	Yes	No	
4. Do you leak stool?	Yes	No	

Ob/Gyn

1. Number of pregnancies: _____deliveries: _____			
2. Last menstrual period: _____ Birth control:_____			
3. Do you ever feel a bulge between your legs?	Yes	No	
4. Have you ever been told you have a dropped bladder?	Yes	No	
5. Do you have vaginal irritation? Dryness? Bleeding?	Yes	No	
6. Do you have pelvic pain or discomfort?	Yes	No	
7. Did your problem get worse with menopause?	Yes	No	
8. Does your problem interfere with you sex life	Yes	No	
9. Do you experience any vaginal discharge?	Yes	No	
10. Are you taking any hormones? *(such as Estrogen or Progesterone)*	Yes	No	
11. Date of last Pap Smear?_____			

Continence History

1. Have you tried Kegel exercise?	Yes	No	
2. Have they helped?	Yes	No	
3. Have you had any previous urological studies?	Yes	No	
What?_____ Where?_____ When?_____			
4. What have you tried to do in order to control your bladder problem? (decreasing fluid intake, etc.)_____			

Other Medical Considerations

1. Do you have glaucoma	Yes	No	
2. Do you have a pacemaker or any other metal devise?	Yes	No	
3. Do you have a chronic cough?	Yes	No	

Fluids

1. Do you have caffeine in your diet?	Yes	No	
2. What do you normally like to drink? _____			
3. How many glasses of water do you drink a day? _____			
4. How many cups of coffee do you drink a day? _____			

What is your main goal in improving you bladder problem?

_____

_____