URINARY HISTORY

Name ____
DOB ____________________
Date of visit ______________

Please describe your current urinary problem:___________________________________

How often do you void during the day (circle one) Every _ hr 1hr 1_ hr 2hr 3hr >3hr

How many times do you get up at night to void (circle one) 0 1 2 3 4 >5

Do you leak urine with coughing, lifting, sneezing, straining or exercise? Yes No

How many protective pads do you wear? (circle one) 0 1 2 3 4 >5
If so, what type of pads? (circle one) panty liners regular pads large pads diapers
Do pads become saturated? Yes __ No___

Are you aware you leaked urine? Yes __ No ___

Is there a sense of urgency before leakage occurs? Yes No

Do you have pain, discomfort, burning, severe urgency, abdominal pain or flank pain?
Yes No

Do you have difficulty initiating the stream, requiring pushing or straining to start?
Yes No

How often do you have a bowel movement? <1per day Daily Every other day
Every __ days

Have you ever had urinary retention (unable to urinate for >6 hours) Yes___ No___

Do you have recurrent urinary tract infections? No___ 2/yr 3/yr 4/yr 5/yr >5/yr

Have you ever had blood in the urine? Yes___ No ___

How many times have you been pregnant? ___ How many children do you have? ___
Vaginal births:____ C-sections:____ Complications:____

Have you ever had treatment for urinary leakage? Yes___ No____
Treatments (please circle) Kegel exercises Bladder retraining Biofeedback
Pelvic floor physical therapy Electrical stimulation
Medications (please list) ____
Bladder or prostate (men) surgery Type: ____________________ When: ____________
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