Name: _____ Date of Birth: _____

Phone Number: _____ Insurance Company:_____

Over the past month, have you leaked urine (even small drops), or wet yourself when you do any of following: Cough, sneeze, change position, walk quickly or exercise.

Not at all	1-2 times a month	1 time a week	3-4 times a week	5-6 days a	Every day	Your Score:
0	1	2	3	4	5	Stress:

Over the past month, have you had a sudden urge to rush to the restroom or when you are undressing to go to the bathroom.

Not at all	1-2 times a month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your Score:
0	1	2	3	4	5	Urgency:

<u>Quality of Life Due to Urinary Leakage</u>

If you were to spend the rest of your life with your urinary incontinence just the way it is now, how would you feel about if? Check one:

___ Happy ___ Mixed ___Unhappy __Satisfied __Mostly dissatisfied __Terrible

Would you be interested in learning more about a cure without medicine or surgery? __Yes or __No

<u>Diet and Lifestyles:</u>

1. Have you ever smoked, or are you currently smoking? __Never __No __Quit __Yes pk/day ___,yrs.

2. If you have gained weight, have your urinary symptoms worsened since you gained weight? __Yes or __No

History:

1. How many times do you get up to urinate at night? _____

788.43

2. Do you feel that you cannot completely empty your bladder? __Yes or __No 788.21

3. Do you notice dribbling of urine after urination? __Yes or __No

788.35

4. Do you take a long time to urinate or have a weak stream? __Yes or __No 788.62

5. Were you ever catheterized because you could not urinate? __Yes or __No

6. Have you ever had your urethra dilated or stretched? __Yes or __No

7. Do you have pain during urination? __Yes or __No

788.1

8. Do you pass blood in your urine? __Yes or __No

599.7

9. Have you ever been treated for 3 or more urinary infections? __Yes or __No 595.2

10. Do you have trouble with your bowels or gas? __Yes or __No

11. Have you ever passed gas without control? __Yes or __No

787.6

12. Have you ever leaked stool without control? __Yes or __No

787.6

13. Do you have constipation? __Yes or __No

564.1

14. Do you have pelvic pain? __Yes or __No

625.9 / 625.6

15. Have you had a Prosthetic joint replacement: check one

__ in the past two years __a previously infected joint __insulin dependent diabetes

__inflammatory arthritis

16. Do you have a cardiac pacemaker/defibrillator? __Yes or __No

Patient's Signature: _____ Date:_____

Physician's Signature: _____ Date:_____