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SUE MOORE, MS, PT, MTC

INCONTINENCE INTAKE QUESTIONAIRE

Name: _____ DOB: _____

Referring MD: _____ Date/ Time completed: _____

1. When did your urinary loss start?
   - ☐ Less than 6 months ago
   - ☐ More than 6 months ago
   - ☐ More than 1 year
   - ☐ More than 2 years
   - ☐ More than 3 years
   - ☐ More than 5 years

2. Was it associated with a specific event?
   - ☐ Childbirth
   - ☐ Surgery
   - ☐ Menopause
   - ☐ Medical illness
   - ☐ Other: _____

3. How has the incontinence changed over time?
   - ☐ Stayed the same
   - ☐ Improved
   - ☐ Worsened

4. When do you lose urine?
   - ☐ Daytime
   - ☐ Nighttime
   - ☐ Both day and night

5. How many times per day do you lose urine?
   - ☐ Once
   - ☐ Twice
   - ☐ Three
   - ☐ More than three
   - ☐ Constantly

Name: _____ Date: _____

6. How much urine do you lose?
   - ☐ Teaspoon
   - ☐ Tablespoon
   - ☐ ½ Cup
   - ☐ More than 1 cupful

7. What type of protection do you use to stay dry?
   - ☐ None
   - ☐ Panty Liner
   - ☐ Mini-Pad
   - ☐ Maxi-Pad
   - ☐ Diaper
   - ☐ Other: _____

8. How often do you change the protection device on an average day?
   - ☐ Zero
   - ☐ Once
   - ☐ Two to three times
   - ☐ Three to four times
   - ☐ Five to six times
   - ☐ More than six times

9. What causes you to lose urine? (Check all that apply)
   - ☐ Cough
   - ☐ Laugh
   - ☐ Sneeze
   - ☐ Putting key in the door
   - ☐ Hand washing
   - ☐ Physical activity
   - ☐ Other: _____

10. Do you have an urge or warning before the bladder accident?
    - ☐ Yes
    - ☐ No

11. Do you lose urine when sitting still?
    - ☐ Yes
    - ☐ No

12. Do you lose urine on the way to the bathroom?
    - ☐ Yes
    - ☐ No

Name: _____ Date: _____

13. How many times do you urinate during the day?
    - ☐ Once
    - ☐ Two to three
    - ☐ Three to four
    - ☐ Five to six
    - ☐ More than six

14. How many times do you wake up to urinate at night?
    - ☐ Zero
    - ☐ Once
    - ☐ Two to three
    - ☐ Three to four
    - ☐ Four to five
    - ☐ Five to six
    - ☐ More than six

15. How many glasses of fluid do you drink per day?
    - ☐ One glass
    - ☐ Two glasses
    - ☐ Three glasses
    - ☐ Three to five glasses
    - ☐ Five to seven glasses
    - ☐ Seven to nine glasses
    - ☐ More than nine glasses

16. Do you feel that you empty your bladder completely?
    - ☐ Yes
    - ☐ No

17. If you have had previous urological surgery, please fill in the blanks with corresponding dates:

    _____
    _____
    _____
    _____

18. If you have had previous gynecological surgery, please fill in the blanks with corresponding dates:

    _____
    _____
    _____
    _____

Name: _____ Date: _____

19. Have you ever seen blood in your urine?
    - ☐ Yes
    - ☐ No

20. A) Do you have a history of urinary tract infections?
    - ☐ Less than 6 months
    - ☐ More than six months

    B) If yes, please state how often in the past year:

    _____

21. How many vaginal deliveries have you had?
    - ☐ Zero
    - ☐ One
    - ☐ Two
    - ☐ Three
    - ☐ Four
    - ☐ Five or more

22. A) Have you had any type of cancer?
    - ☐ Yes
    - ☐ No

    B) If yes, please describe:

    _____

23. Have you been diagnosed with any of the following conditions?
    - ☐ Neurological problems
    - ☐ Multiple sclerosis
    - ☐ Parkinson's disease
    - ☐ Stroke
    - ☐ Disc problem
    - ☐ Back problems
    - ☐ Spinal injury

24. A) Do you have diabetes?
    - ☐ Yes
    - ☐ No

    B) If yes, do you take insulin?
    - ☐ Yes
    - ☐ No

Name: _____ Date: _____

25. A) Do you have hypertension?
    - ☐ Yes
    - ☐ No

    B) If yes, do you take a diuretic?
    - ☐ Yes
    - ☐ No

26. Do you have glaucoma?
    - ☐ Yes
    - ☐ No

27. Please check any of the following conditions that apply to you:
    - ☐ Heart disease
    - ☐ Lung disease
    - ☐ Stomach problems
    - ☐ Liver problems
    - ☐ Bowel Problems
    - ☐ Other: _____

28. Do you have allergies; if yes please specify:
    - ☐ Yes : _____
    - ☐ No

29. Please list all the medications you take, including over-the-counter medications:

    _____
    _____
    _____
    _____
    _____
    _____

30. Please list any medication you have taken in the past to treat your bladder condition:

    _____
    _____
    _____
    _____
    _____
    _____

Name: _____ Date: _____

31. Did the previously listed medications help your bladder?
    - ☐ Yes
    - ☐ No

32. Please list the names and addresses of the doctors that you would like to receive a report of you urinary evaluation:

_____
_____
_____
_____
_____
_____
_____

33. Please identify the name and telephone number of the pharmacy that you currently use:

_____
_____
_____
_____
_____
_____
_____

34. Please use this space to list anything else that you feel may be important about your bladder condition:

_____
_____
_____
_____
_____
_____
_____