

# Incontinence and Pelvic Prolapse Patient Information Form

Before talking with you, Dr. Edwards would like some information about your current issues. These questions are important in determining the cause of the problem and recommending treatment options. She will discuss some of your answers during your visit.

Name \_\_\_\_\_ Date \_\_\_\_\_

Referring Physician \_\_\_\_\_

*What changes would you like to see in your symptoms as a result of your treatment here?*

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## Bladder Control

How long have you had urine leakage? \_\_\_\_\_

When did your problem with urine leakage begin? Check all that apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> During pregnancy | <input type="checkbox"/> After an operation  | <input type="checkbox"/> After menopause            |
| <input type="checkbox"/> After childbirth | <input type="checkbox"/> After a back injury | <input type="checkbox"/> After changing medications |
| <input type="checkbox"/> Other            |  |   |

How often do you leak urine?

How much urine do you leak each day?

Have you ever been treated for your bladder leakage?

Check all treatments you have received in the past

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Surgery          | <input type="checkbox"/> Medications            | <input type="checkbox"/> Pelvic muscle exercises |
| <input type="checkbox"/> Bladder training | <input type="checkbox"/> Electrical Stimulation |  |

Circle all self-help techniques you have tried

- |   |  |
|---|--|
| <input type="checkbox"/> Pads/diapers                     | <input type="checkbox"/> Limiting fluid intake   |
| <input type="checkbox"/> Going to the bathroom frequently | <input type="checkbox"/> Staying near a bathroom |
| <input type="checkbox"/> Other                            |  |

Which medications have you tried to control urine leakage?

<u>Medication</u>	<u>Was the medication helpful?</u>	
<input type="checkbox"/> Ditropan (oxybutinin)	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Detrol	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Oxytrol patches	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Levsin, Cystospas (hysocamine)	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Trofranil (imipramine)	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Elavil (amitriptyline)	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Urispas	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Others	<input type="checkbox"/> yes	<input type="checkbox"/> no

Have you had any bladder surgery?

Type of surgery \_\_\_\_\_ Date \_\_\_\_\_ Was the surgery helpful? Yes No

Activities Leading to Urine Leakage

*Check how often each of the following activities leads to a loss of urine*

Changing positions from sitting to standing up

Never Rarely Sometimes Often Always

Running

Never Rarely Sometimes Often Always

Sneezing or coughing

Never Rarely Sometimes Often Always

Laughing

Never Rarely Sometimes Often Always

Lifting

Never Rarely Sometimes Often Always

Bending down

Never Rarely Sometimes Often Always

Reaching

Never Rarely Sometimes Often Always

Rushing to the toilet

Never Rarely Sometimes Often Always

Running water

Never Rarely Sometimes Often Always

Washing your hands

Never Rarely Sometimes Often Always

Do you leak urine during sex?

Yes No Not sexually active

Do you ever find yourself wet or damp and you did not realize you had an accident?

Never Rarely Sometimes Often Always

Once your bladder is full, how long can you hold your urine?

As long as I need to A few minutes  
Less than a minute or two I cannot tell when bladder is full

Do you wake up in the night to urinate? Yes No

If yes, how often?

Check any of the following that occur when you urinate

- Difficulty getting urine started
- Very slow stream or dribbling
- Discomfort or pain
- Blood in the urine
- Feeling that bladder did not empty completely

Check any of the following problems you have experienced and the date of their occurrence

- Bladder tumor – Date \_\_\_\_\_
- Radiation treatment to the pelvis – Date \_\_\_\_\_
- Recurrent urinary tract or bladder infections – Date \_\_\_\_\_
- Kidney stones – Date \_\_\_\_\_

**Bowel Control**

Do you have constipation?

Never      Rarely      Sometimes      Often      Always

Do you have diarrhea?

Never      Rarely      Sometimes      Often      Always

Do you have pass gas uncontrollably?

Never      Rarely      Sometimes      Often      Always

Do you pass stool uncontrollably when you have diarrhea?

Never      Rarely      Sometimes      Often      Always

Do you pass stool uncontrollably when your stools are solid?

Never      Rarely      Sometimes      Often      Always

Do you have difficulty emptying your bowels completely?

Never      Rarely      Sometimes      Often      Always

Do you have to strain in order to have a bowel movement?

Never      Rarely      Sometimes      Often      Always

Do you have to push on the vaginal walls to have a bowel movement?

Never      Rarely      Sometimes      Often      Always

**Menstrual History**

Have you experienced menopause? Yes No

If yes,

Date of last menstrual period \_\_\_\_\_

Are you taking hormone replacement therapy (HRT)?  Yes  No

When did you begin HRT? \_\_\_\_\_

If no,

Date of last menstrual period \_\_\_\_\_

# of days between periods \_\_\_\_\_

# of days of menstrual flow \_\_\_\_\_

Do you have excessive bleeding? \_\_\_\_\_

Do you have irregular bleeding? \_\_\_\_\_

Contraceptive method \_\_\_\_\_

Are you planning more children? \_\_\_\_\_

Have you had a hysterectomy? Yes No

If yes,

Reason for hysterectomy \_\_\_\_\_

How was the hysterectomy performed? Abdomen Vagina

Were the ovaries removed? Yes No

Do you have any other gynecologic conditions? \_\_\_\_\_

**Habits**

How many glasses of fluid do you drink each day? \_\_\_\_\_

Do you drink coffee, tea, or soda products with caffeine?

No            Yes    How much? \_\_\_\_\_

Do you drink alcohol?

No            Yes    How much? \_\_\_\_\_

Do you drink fluids that contain artificial sweeteners?

No            Yes    How much? \_\_\_\_\_

How much fluid do you drink in the two hours before you go to bed? \_\_\_\_\_

Do you smoke cigarettes?

No            Yes    How much? \_\_\_\_\_

Do you know how to do Kegel exercises? Yes No

Do you practice Kegel exercises regularly? Yes No

**Thank you for your help. When you come for your evaluation, please try not to empty your bladder before your visit. Some of the tests we will be performing are more useful when done with a full bladder.**