Incontinence and Pelvic Prolapse Patient History

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?

_____
_____
_____
_____.

Bladder Control

How long have you had urine leakage? _____

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

- ☐ During pregnancy
- ☐ After menopause
- ☐ After childbirth
- ☐ Other
- ☐ After an operation
- ☐ After a back injury
- ☐ After changing medications

How often do you leak urine?

How much urine do you leak each day?

Check all treatments you have received in the past for bladder leakage

- ☐ Surgery
- ☐ Medications
- ☐ Pelvic muscle exercises
- ☐ Bladder training
- ☐ Electrical Stimulation

Have you had any bladder surgery?
Type of surgery _____Date_____
Was the surgery helpful? ☐ Yes ☐ No

Circle all self-help techniques you have tried

- ☐ Pads/diapers
- ☐ Limiting fluid intake
- ☐ Going to the bathroom frequently
- ☐ Staying near a bathroom
- ☐ Other

Which medications have you tried to control urine leakage?

Medication	Was the medication helpful?	
☐Ditropan (oxybutinin)	☐ yes	☐ no
☐Detrol	☐ yes	☐ no
☐Oxytrol patches	☐ yes	☐ no
☐Enablex	☐ yes	☐ no
☐Sanctura	☐ yes	☐ no
☐Vesicare	☐ yes	☐ no
☐Myrbetriq	☐ yes	☐ no
☐Others	☐ yes	☐ no

Activities Leading to Urine Leakage

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

Changing positions form 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 intercourse?
☐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 it is full

Do you wake up in the night to urinate? ☐Yes ☐No
If yes, how often?

Are you aware of a bulge at the opening of your vagina? ☐Yes ☐No

Do you have to press in your vagina to empty your bladder? ☐Yes ☐No

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

Do you experience pelvic pressure or heaviness? ☐Yes ☐No

Do you experience low back pain? ☐Yes ☐No

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.