



Bladder Health Questionnaire

Name: _____ Date: _____

1. How often do you urinate during the day? _____
2. How often do you get up at night to urinate? _____
3. Is the amount of urine you usually pass: Large Average Small
4. Do you usually have a strong sense of urgency to urinate? No Yes
5. Do you have to hurry to empty your bladder when full? No Yes
6. Do you ever not make it in time and leak urine? No Yes
7. Can you overcome the sensation of urgency to urinate? No Yes
8. Does the sight, sound or feel of running water cause you to lose your urine? No Yes
9. Do you ever lose urine when lying down? No Yes
10. Do you have a warning before losing urine? No Yes
11. When urinating, can you usually stop your stream? No Yes
12. Do you ever accidentally wet the bed while asleep? No Yes
13. Do you have difficulty starting your urine stream? No Yes
14. Do you feel that you completely empty your bladder? No Yes
15. Do you notice dribbling of urine after voiding? No Yes
16. Were you ever catheterized because you were unable to void? No Yes
17. Have you ever had your urethra dilated or stretched? No Yes
18. Do you ever pass blood in your urine? No Yes
 - Have you ever passed sand, gravel, or stones? No Yes
 - Do you have pain during urination? No Yes
19. Have you been treated for 3 or more urinary infections? No Yes
 - Have you been treated for an infection within 6 months? No Yes
20. Do you lose urine while coughing, sneezing, laughing, lifting, jumping, or running? No Yes
 - Do you find it necessary to use some type of protection? No Yes
21. Did your urinary difficulty begin:
 - During a pregnancy? No Yes
 - Following a delivery? No Yes
 - Following an abdominal or vaginal operation? No Yes
 - After the menopause? No Yes
22. List all medications you have taken in the past 6 months. Circle the medications you are currently taking.