UNIVERSITY UROLOGY ASSOCIATES of New Jersey
UUANJ

BLADDER SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

Which symptoms best describe you? Check all that apply.

☐ Frequent urination—day, night, or both
☐ Sudden or strong urge to urinate
☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
☐ Bladder or pelvic pain
☐ Problems with bowel function (if checked, please select symptom below)
  ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried?_____

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? ☐ Yes ☐ No

If no, why have you stopped taking them?

☐ Did not work as well as expected ☐ Side effects ☐ Expense
☐ Interaction with other medications ☐ Other

If Side effects or Other checked, please explain:

_____

Behavior modifications tried? _____
(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Extremely Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No