URODYNAMIC QUESTIONNAIRE

PATIENT NAME:____________________ PHYSICIAN :______________ DATE:____/____/20____

Daytime voiding frequency: How often do you urinate during the day? (check one)
○ *more than 10* ○ *7-10 times per day* ○ *4-6 times per day* ○ *1-3 times per day*

Night time voiding: How often do you get up at night to urinate? (check one)
○ *awakened 3 or more times per night* ○ *2 times per night* ○ *1 time per night* ○ *accidentally void while sleeping*

Question	Answer
Do you usually have a strong sense of urgency to urinate? ***(Urinary Urgency)***	○ *yes* ○ *no*
Do you sometimes not make it fast enough to the bathroom, and leak urine as a result? ***(Urgency Urinary Incontinence)***	○ *yes* ○ *no*
Do you leak urine with sudden strong movements? Do you leak urine when moving from sitting to standing position? Do you leak urine when you cough, sneeze, laugh, jump, run, lift, etc.? ***(Stress Urinary Incontinence)***	○ *yes* ○ *no* ○ *yes* ○ *no* ○ *yes* ○ *no*
Do you find it necessary to use some type of protection? (i.e. napkins, pads, diapers) *If yes, how many per day?*	○ *yes* ○ *no*

Is your urinary flow: (check all that apply)
○ *Normal* ○ *Slow* ○ *Weak* ○ *Variable* ○ *Intermittent* ○ *Hesitancy* ○ *Straining*

Question	Answer
Do you feel that you have completely emptied your bladder after urinating?	○ *yes* ○ *no*
After voiding do you have any post dribble/leaking? ***(Post Void Dribbling)***	○ *yes* ○ *no*
Have you had any prior surgical procedures for urinary / incontinence issues: *If yes, Type:*	○ *yes* ○ *no*

How many births have you had:________________

Number of deliveries: Vaginal__________ C-Section__________ Size of babies: __________

Describe the degree of your symptoms (1-10, 10 being the worst)? (circle one) 1 2 3 4 5 6 7 8 9 10

How many urinary tract infections/bladder infections have you had in the last 12 months?

Please list all urinary medications you have used in the past or are currently on: