

HINSDALE & OAKBROOK WOMEN'S CLINIC

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Bladder Health Questionnaire

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
- Do you have to hurry to empty your bladder when full? No Yes
- Do you ever not make it in time and leak urine? No Yes
- Can you overcome the sensation or urgency to urinate? No Yes
- Does the sight, sound, or feel of running water cause you to lose your urine? No Yes
- Do you ever lose urine when lying down? No Yes
- Do you have a warning before losing urine? No Yes
- When urinating, can you usually stop your stream? No Yes
- Do you ever accidentally wet the bed while asleep? No Yes
5. Do you have difficulty starting your urine stream? No Yes
- Do you feel that you completely empty your bladder? No Yes
- Do you notice dribbling of urine after voiding? No Yes
6. Were you ever catheterized because you were unable to void? No Yes
- Have you ever had your urethra dilated or stretched? No Yes
- Do you ever pass blood in your urine? No Yes

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| | Have you ever passed sand, gravel or stones? | No | Yes |
| | Do you have pain during urination? | No | Yes |
| 7. | Have you been treated for 3 or more urinary infections? | No | Yes |
| | Have you been treated for an infection within 6 months? | No | Yes |
| 8. | 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 |
| 9. | Did your urinary difficulty begin: | | |
| | During a pregnancy? | No | Yes |
| | Following a delivery? | No | Yes |
| | Following a delivery? | No | Yes |
| | Following an abdominal or vaginal operation? | No | Yes |
| | After the menopause? | No | Yes |
| 10. | List all medications you have taken in the past 6 months.
Circle those medications you are presently taking. | | |
