Female Health Questionnaire

Name:
Date:

Question		
Do you leak urine?	Yes	No
Do you leak when you cough, laugh Sneeze or with other activities?	Yes	No
Do you have difficulty making it to the bathroom on time?	Yes	No
Does running water stimulate an urge to urinate?	Yes	No
Do you have difficulty urinating?	Yes	No
Do you have difficulty starting to urinate?	Yes	No
Do you have a slow stream?	Yes	No
Do you have to strain or push to urinate?	Yes	No
Do you feel empty after urination?	Yes	No

How often do you urinate during the day? (please circle)
3-6 7-10 11-14 15+

How many times a night do you get up to urinate? (please circle)
0 1-2 2-3 3-4 4-5 5-6 6-7 7-8 8-9

Have you been on any medications for these problems?
If so please circle and indicate how long.

Detrol	Sanctura	Toviaz
Ditropan	Vesicare	Other_____________
Enablex	Oxytrol Patch	

Do you feel a bulge in your vagina? Yes No

Do you feel like your bladder is falling? Yes No

How many c-sections have you had? ____________________

How many vaginal births have you had? ____________________

Have you had a hysterectomy? Yes No

Was It Vaginal or Abdominal? ________________

Do you still have your ovaries? Yes No

Have you ever had a bladder tack or any other vaginal surgery? ________________ Yes No

Do you have difficulty moving your bowels? Yes No