Bladder Program Questionnaire

Patient Name: _____

Date of First Visit: _____

History (Description of bladder, pelvic or bowel symptoms in your own words):

_____

_____

_____

Please Circle Appropriate Answer:

Duration of symptoms

1. 1-2 months
2. 3-6 months
3. 6-12 months
4. 1-3 years
5. 3-5 years
6. 5-10 years
7. 10+ years

Daytime voiding frequency

1. Less than 30 minutes
2. 30-60 minutes
3. 1-2 hours
4. 2-4 hours
5. 4-6 hours

Nocturia (night-time voiding)

1. None
2. 1-2 times
3. 2-4 times
4. 4-6 times
5. Other_____

Average number of urinary leaks in a 24 hour period

- None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Average number of pads used in a 24 hour period

- None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Type of pad predominately used

- None
- Adult diaper
- Poise
- Light panty liner
- Menstrual
- Mini
- Homemade product
- Tissue

Have you ever noticed blood in your urine?

- Yes
- No

Can you feel when you leak?

- Yes
- No
- Sometimes

Number of treated urinary tract infections in the last year

- None
- 1-2
- 3-5
- 5+

What causes you to leak? (circle all that apply)

- Urgency
- Frequency
- Resting
- Coughing
- Exercising
- Laughing
- Lifting
- Position change
- Running
- Running water
- Sitting
- Sneezing
- Walking
- Sexual Intercourse
- Other_____

Medical and Surgical History

Known drug allergies

- Aspirin
- Cephalosporin
- Demerol
- Erythromycin
- Macrodantin
- Penicillin
- Quinolones

- Sulfa
- Morphine sulfate
- Iodine
- Other _____
- No known allergies

Medical History (past and present)

- High blood pressure
- High cholesterol
- Thyroid conditions
- Bowel diseases
- Abdominal/inguinal hernia
- Uterine/ovarian cancer
- Psychiatric disorders
- Circulatory disorders
- Prostate cancer
- Bladder cancer
- Interstitial Cystitis
- Diabetes
- Eye Disorders
- Kidney Stones
- Seizure Activity
- Irregular Heart Rhythm
- Other _____

General Surgical History

- Appendix
- Gallbladder
- Hernia repair
- Rectal surgeries
- Bowel surgeries
- Pacemaker or implanted medication pumps/ Defibrillator
- Spinal surgery
- Other _____

GYN History

- C-section
- Hysterectomy (abdominal or vaginal)
- Oophorectomy (partial or bilateral)
- Vaginal delivery
- D&C

- Endometriosis
- Abnormal Pap Smear
- Uterine or cervical biopsy
- Number of pregnancies _____
- Number of live births _____
- Episiotomy(s) and number of them _____
- Vaginal infections; if yes what kind _____

Urological Surgical Procedures

- Bladder suspension
- Bladder resection
- Cystoscopy
- Nephrectomy
- Radical Prostatectomy
- Urodynamics
- Intravenous Pyelogram
- Transurethral resection of the prostate
- Removal of Bladder
- Urethral Sound Procedures, number of them
- Renal Stent placement or removal
- Robotic Prostatectomy
- TURMC
- Other _____

Social History

Types of fluids consumed:

- Water
- Tea
- Coffee
- Diet soda
- Regular soda
- Fruit juice
- Milk
- Chocolate milk
- Power drinks
- Weight loss drinks
- Other _____

How many cups of caffeine consumed per day?

- 1
- 2

- 3
- 4
- 5
- 5+

How many cups of fluid a day, including caffeine?

- 1
- 2
- 3
- 4
- 5 or more
- 10 or more

Smoking habit

- Half pack
- One pack (or more)
- Never
- Currently
- Previous 1-3 years
- Previous 4-5 years
- Previous 6-10 years
- Previous 11-15 years
- Previous 16-20 years
- Previous 20+ years

Alcohol usage

- Yes
- If yes, how many per day, per week, per month _____
- No

Bowel habits

- Regular
- Diarrhea
- Constipation

Pelvic Pain Assessment

Do you have pelvic (lower abdomen) discomfort?

- Yes
- No

If yes, how long? _____ Past Diagnosis _____

If you answered yes, grade the severity on a scale of 1-10 (with 10 being the worst) _____

What past or present treatment(s) have you received for your pelvic pain _____

What makes it better? _____

What makes it worse? _____

Describe the quality of discomfort

- Sharp
- Dull
- Constant
- It moves from place to place
- It comes and goes
- Other

Bowel Disorders/Dysfunction Assessment

Other bowel disorders _____

What past or present treatment have you received for your bowel discomfort?

_____

_____

What makes it better? _____

What makes it worse? _____

Grade level/severity of bowel discomfort on a scale of 1-10 (with 10 being the worst)

- Sharp
- Dull
- Constant
- It moves from place to place
- It comes and goes
- Other

Do you have leakage of stool?

- Yes
- No

What past or present treatments have you received for leakage of stool?

_____

_____

Bowel Dysfunction Assessment

Patient Name_____ Date _____

In a sentence, please describe your bowel problem: _____
_____

When did this problem begin? _____ (date)

1. **Do you lose stool**:
   a. By continuous oozing __Always __ Sometimes __Never
   b. In small amounts __Always __Sometimes __Never
   c. In moderate amounts __Always __Sometimes __Never
   d. In sudden large amounts __Always __Sometimes __Never
   e. Other, specify __Always __Sometimes __Never
2. **What is the consistency of stool loss**:
   a. Formed __Always __Sometimes __Never
   b. Hard __Always __Sometimes __Never
   c. Liquid __Always __Sometimes __Never
   d. Stringy __Always __Sometimes __Never
   e. Other, specify __Always __Sometimes __Never
3. **Are your episodes of stool loss**:
   a. Mostly during the day __ Yes __No
   b. Always during the day __Yes __No
   c. Mostly at night __Yes __No
   d. Always at night __Yes __No
   e. ½ during the day, ½ during the night __Yes __No
   f. Less than weekly __Yes __No
   g. Once a week __Yes __No
   h. 2 to 6 times per week __Yes __No
   i. Daily or more __Yes __No
4. **Before an accident occurs do you have**:
   a. Urge sensation to pass your bowels __Yes __No
   b. No urge sensation __Yes __No
5. **Do you lose stool with any of the following**:
   a. Coughing/Sneezing __ Always __ Sometimes __ Never
   b. Laughing __ Always __ Sometimes __ Never
   c. Lifting heavy objects __ Always __ Sometimes __ Never
   d. Active exercise such as running __ Always __ Sometimes __ Never
   e. Minimal exercise __ Always __ Sometimes __ Never

f. On the way to the bathroom __ Always __ Sometimes __ Never
g. Nervousness __ Always __ Sometimes __ Never
h. Leakage unrelated to a specific cause __ Always __ Sometimes __ Never
i. Changing of positions (sitting or standing) __ Always __ Sometimes __ Never

6. **Do you wear a pad**?
   a. If so, how many per day _____ Type: _____
7. **At the time of changing pads, are the pads**:
   a. Slightly soiled __ Always __ Sometimes __ Never
   b. Moderately soiled __ Always __ Sometimes __ Never
   c. Largely soiled __ Always __ Sometimes __ Never
8. **Is there a relationship between accidents and**:
   a. Meals __ Always __ Sometimes __ Never
   b. Activity __ Always __ Sometimes __ Never
   c. Flatulence (gas) __ Always __ Sometimes __ Never
   d. Certain foods __ Always __ Sometimes __ Never
   e. If so, what type of food: _____
   f. Other, specify _____
9. **Did your problem begin after any of the following**:
   a. Back surgery/trauma __ Yes __ No
   b. Brain surgery __ Yes __ No
   c. Bowel surgery __ Yes __ No
   d. Stroke __ Yes __ No
   e. Rectal surgery __ Yes __ No
   f. Cancer diagnosis __ Yes __ No
   g. Radiation therapy __ Yes __ No
   h. Vaginal delivery __ Yes __ No
   i. Episiotomy __ Yes __ No
   j. Other, specify _____
10. **History of bowel studies**:
    a. Barium enema __ Yes __ No __ Don't know Date _____
    b. Sigmoidoscopy __ Yes __ No __ Don't know Date _____
    c. Ultrasound __ Yes __ No __ Don't know Date _____
    d. CAT scan/ MRI __ Yes __ No __ Don't know Date _____
    e. Other, specify _____
11. **Describe your daily intake of foods high in fiber**: _____
    _____
12. **Have you done exercises for bowel problems**? __ Yes __ No
    a. If yes, please describe the exercises _____

Reviewed By _____ **Date** _____

HIPPA COMPLIANCE PLAIN BUSINESS ASSOCIATE LIST

The following list contains the business associates to whom we may disclose any form of personal health information on our patients. This is an ongoing list. This list will be included in the disclosure document released to the patients. These associates have a need to know or come in contact with patient information. The laboratories are included however are exempt under CLIA '88 for disclosure to anyone except the healthcare providers who order the tests.

The list and compliance became effective April 14, 2003

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

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Address: _____

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Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Patient Signature: _____ **Date:** _____