All About Women
OBSTETRICS AND GYNECOLOGY

Bladder Survey

Please fill out the following information to help us better treat your needs.

Your Name *(required)*_____ **Your Email** *(required)* _____

Phone _____ **Doctor** *(required)* _____

1 . Which symptoms best describe you? *(Please click all that apply)*

- ☐ Frequent Urination – Day, Night, or Both
- ☐ Sudden or Strong Urge to urinate
- ☐ Unable to Empty the Bladder
- ☐ None of the above *(You are finished with questionnaire)*
- ☐ Leaking with Sneezing, Coughing, Exercising
- ☐ Leaking with Urge or No Warning *(Unable to make it to the bathroom in time*
- ☐ Bladder or Pelvic Pain

2. How long have you had these symptoms?

- ☐ 1 week or less
- ☐ 1-2 weeks
- ☐ 2-4 weeks
- ☐ Over 1 month
- ☐ Over 2 months
- ☐ 3-6 months
- ☐ 6 moths - 1 year
- ☐ 1 year or more

3. Have you tried medications to help your symptoms?

- ☐ yes
- ☐ no

If yes, select the medications you have tried:

- ☐ Detrol®
- ☐ LADitropan XL® Flomax®
- ☐ Myrbetriq®
- ☐ Oxytrol® Patch
- ☐ Enablex®
- ☐ Sanctura®
- ☐ VESIcare® Toviaz®
- ☐ Elavil®
- ☐ Elmiron®
- ☐ Other

4. Did these medications help your symptoms? *Select one. 1 = No relief 10=Completely Cured*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. If you've stopped taking your meds explain why:

☐ Did not Help ☐ Side Effects ☐ Other _____

6. What is your level of frustration with your bladder symptoms? *Select one. 1=Not Frustrated 10=Very Frustrated*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. Do you currently have any problems with bowel function?

☐ No Bowel Incontinence ☐ Constipation ☐ Other_____

8. Comments

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