THE UROLOGY GROUP

www.urologygroupvirginia.com

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URINARY HISTORY

Name:_____DOB:_____Date of Visit:_____

Please describe your current urinary problem:_____

When did symptoms start?_____

How often do you void during the day? (circle one) Every ½ hr 1 hr 1½ hr 2 hr 3 hr >3 hr

How many times do you get up at night to void? (circle one) 0 1 2 3 4 >5

Do you leak urine with coughing, lifting, sneezing, straining or exercise? Yes_____ No_____

How many protective pads do you wear? (circle one) 0 1 2 3 4 >5

If so, what type of pads? (circle one) panty liners regular pads large pads diapers

Do pads become saturated? Yes_____No_____

Are you aware you leaked urine? Yes_____No_____

Is there a sense of urgency before leakage occurs? Yes_____ No_____

Do you have pain, discomfort, burning, severe urgency, abdominal pain or flank pain? Yes_____ No_____

Do you have difficulty initiating the stream, requiring pushing or straining to start? Yes_____No_____

How often do you have a bowel movement? >1 per day Daily Every other day Every_____days

Have you ever had urinary retention (unable to urinate for >6 hours) Yes_____No_____

Do you have recurrent urinary tract infections? No_____ 2/yr 3/yr 4/yr 5/yr >5/yr

Have you ever had blood in the urine? Yes_____ No_____

How many times have you been pregnant?_____How many children do you have? _____

Vaginal births:_____ C-sections:_____ Complications:_____

Have you ever treatment for urinary leakage? Yes_____ No_____

Treatments (please circle) Kegel exercises Bladder retraining Biofeedback

Pelvic floor physical therapy Electrical stimulation

Medications (please list)_____

Bladder or prostate (men) surgery Type:_____When:_____