NEW JERSEY UROLOGY
Excellence In Care

Bladder Symptom Questionnaire

Patient Name:_____ **Date of Birth**:_____

What Physician are you seeing today?_____

Which symptoms best describe what you are experiencing?

- ☐ Frequent Urination
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning – sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty bladder – feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity – exercising, sneezing or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other

How long have you had these symptoms?_____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried?_____

On a scale from zero (0) to ten (10), with zero being no symptom relief and ten being complete symptom relief, how much symptom relief have these medications provided you? Please circle a number:

No Relief **Complete Relief**

0	1	2	3	4	5	6	7	8	9	10

Are you still taking any of these medications? ☐ **Yes** ☐ **No**

If no, why have you stopped taking them? ☐ Did not work as well as expected ☐ Side effects ☐ Expense ☐ Interaction with other medications ☐ Other

If side effects or other, please explain:_____

Behavior modifications tried? ☐ Reduced fluid intake ☐ Caffeine reduction ☐ Kegel exercises ☐ Physical therapy ☐ Lifestyle changes

On a scale from zero (0) to ten (10), with zero being no frustration and ten being extremely frustrated, what is your level of frustration with your bladder control symptoms. Please circle a number:

Not Frustrated **Extremely Frustrated**

0	1	2	3	4	5	6	7	8	9	10

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No