

**BLADDER SURVEY**

Name \_\_\_\_\_ Dob \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

I have read the information below and it does not apply to me. Signature: \_\_\_\_\_

**Which symptoms best describe you?**

- Frequent Urination – Day, Night, or Both
- Leaking with - Sneezing, Coughing, Exercising
- Sudden or Strong Urge to urinate
- Leaking with Urge or No Warning (Unable to make it in time)
- Unable to Empty the Bladder
- Bladder or Pelvic Pain

**Do you visit the bathroom more than 7 times in a 24-hour period?**  Yes  No

**When preparing for a trip, outing or event, does the availability of restroom facilities affect your plan?**  
 Yes  No

**How long have you had these symptoms?** \_\_\_\_\_

**Have you tried medications to help your symptoms? If yes, check the medications you have tried:**

- Cardura
- DDAVP
- Detrol LA
- Ditropan XL
- Elavil
- Flomax
- Enablex
- Gelnique
- Oxytrol Patch
- Vesicare
- Toviaz
- Sanctura
- Trosipium
- Myrbetriq
- Gemtesa
- \_\_\_\_\_

**Did these medications help your symptoms? Circle #**

0	1	2	3	4	5	6	7	8	9	10
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**No Relief**

**Completely Cured**

**If you've stopped taking your meds explain why:**

- Did not Help
- Side Effects
- Too Expensive

**Describe Side Effects** \_\_\_\_\_

**Behavior Modifications Tried** \_\_\_\_\_

(i.e., caffeine intake, diet changes, lifestyle changes, bladder training, pelvic floor muscle training)

**What is your level of frustration with your bladder symptoms? Circle #**

0	1	2	3	4	5	6	7	8	9	10
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**Not Frustrated**

**Very Frustrated**

**Do you currently have any problems with bowel function?**

- Fecal Incontinence
- Constipation
- Other \_\_\_\_\_

**I am interested in learning more about treatment alternatives to medications:**

- Yes
- No