

Internal Medicine Associates URODYNAMICS QUESTIONNAIRE

Patient Name: _____

Physician: _____ Date: ____ / ____ / 20____

Daytime voiding frequency: How often do you urinate during the day? (check one) <input type="radio"/> <i>more than 10</i> <input type="radio"/> <i>7-10 times per day</i> <input type="radio"/> <i>4-6 times per day</i> <input type="radio"/> <i>1-3 times per day</i>	
Night time voiding: How often do you get up at night to urinate? (check one) <input type="radio"/> <i>awakened 3 or more times per night</i> <input type="radio"/> <i>2 times per night</i> <input type="radio"/> <i>1 time per night</i> <input type="radio"/> <i>accidentally void while sleeping</i>	
Do you usually have a strong sense of urgency to urinate? (<i>Urinary Urgency</i>)	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
Do you sometimes not make it fast enough to the bathroom, and leak urine as a result? (<i>Urgency Urinary Incontinence</i>)	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
Do you leak urine with sudden strong movements? Do you leak urine when moving from sitting to standing position? Do you leak urine when you cough, sneeze, laugh, jump, run, lift, etc.? (<i>Stress Urinary Incontinence</i>)	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i> <input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i> <input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
Do you find it necessary to use some type of protection? (i.e. napkins, pads, diapers) <i>If yes, how many per day?</i>	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
Do you feel that you have not completely emptied your bladder after urinating?	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
After voiding do you have any post dribble/leaking?	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
Is your urinary flow: (check all that apply) <input type="radio"/> <i>Normal</i> <input type="radio"/> <i>Slow</i> <input type="radio"/> <i>Weak</i> <input type="radio"/> <i>Variable</i> <input type="radio"/> <i>Intermittent</i> <input type="radio"/> <i>Hesitancy</i> <input type="radio"/> <i>Straining</i>	
Have you had any prior surgical procedures for urinary / incontinence issues: <i>If yes, Type:</i>	<input type="radio"/> <i>yes</i> <input type="radio"/> <i>no</i>
How many babies have you had: _____ Number of deliveries: Vaginal _____ C-Section _____ Size of babies: _____	
Describe the degree of your symptoms (1-10, 10 being the worst)? (circle one) 1 2 3 4 5 6 7 8 9 10	
How many urinary tract infections/bladder infections have you had in the last 12 months?	
Please list all urinary medications you have used in the past or are currently on:	

*****Please tell your doctor if you need to pre-medicate prior to dental procedures*****