BLADDER SATISFACTION SURVEY

Name______________________________ Phone #__________________________

Doctor __________________________

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 to the bathroom in time)

☐Unable to Empty the Bladder ☐Bladder or Pelvic Pain

How long have you had these symptoms? __________________________

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

If yes, check the medications you have tried:

☐Detrol LA ☐Ditropan XL ☐Flomax ☐Cardura

☐Oxytrol Patch ☐Enablex ☐Vesicare ☐DDAVP

☐Sanctura ☐Elavil ☐Elmiron ☐Other_________________

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

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, 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

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

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions. Thank you!

Name____ Date____________________

CONTRACEPTION

1. What is your current form of birth control? ____
2. How long have you been using your current form of birth control? *(please check one)*
   __ Two years or less __ 3 to 5 years __ 6 to 10 years __ Over 10 years
3. When are you planning to have another child? *(please check one)*
   __ Within the next year __ Within the next 5 years
   __ Within the next 10 years __ I am done having children

MENSTRUAL PERIODS

1. How long does your average monthly period last? ____________ days
2. Do you ever feel as though your periods impact the quality of your life? __ Yes __ No
3. Do you ever experience irregular or inconsistent bleeding patterns? __ Yes __ No

URINARY HEALTH

1. Do you ever leak urine when you cough, laugh or sneeze? __ Yes __ No
2. Do you ever feel as though you have to urinate urgently? __ Yes __ No
3. Do you feel like you have to urinate too frequently? __ Yes __ No
4. Do you ever experience painful urination? __ Yes __ No

Are there any concerns/issues that you would like to discuss today?______________________________

____

____