

Patient Name: _____

Date of Birth: _____



PROLAPSE and INCONTINENCE QUESTIONNAIRE

Please answer the following questions about your condition. This will help your doctor in the evaluation of your problems.

1. Have you ever had treatment for urinary tract problems? Yes No If Yes, what? Stones Kidney disease Tumors
2. Have you had frequent urinary or bladder infections? Yes No
3. Is your urine ever bloody? Yes No
4. Is it usually painful or difficult for you to pass urine? Yes No
5. Is it necessary for you to change positions (sitting to standing or bend over) in order to empty your bladder? Yes No
6. Do you leak urine (even small drops), wet yourself, or wet your undergarments? (CHECK ONE FOR EACH QUESTION)
 - ~ When you cough or sneeze?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ When you bend down or lift something up?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ When you walk quickly, jog, or exercise?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ While you are undressing to use the toilet?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ Do you get such a strong and uncomfortable need to urinate that you leak urine, (even small drops) or wet yourself before reaching the toilet?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ Do you have to rush to the bathroom because you get a sudden strong need to urinate?
 None of the time Rarely Once in a while Often Most of the time All of the time
7. Do you find it necessary to wear protection because of leakage of urine? Yes No
If yes - number of pads / protection per day: _____ Clothing changes per day? _____
8. Do you feel a bulge in your vagina or that something is falling out from your vagina? Yes No
9. Do you ever lose control of your bowels (leak stool onto your clothing)? Yes No
10. Do you ever need to push with a finger in the vagina or rectum to help stool get out? Yes No
11. Do you have a problem with constipation? Yes No
12. How much are you bothered by your problems with your bladder/leakage of urine?
 Not at all Somewhat Moderately Quite a bit
- ~ How much are you bothered by your prolapse (vaginal bulge)?
 Not at all Somewhat Moderately Quite a bit
13. Are you currently sexually active? Yes No a. If No, are you without a partner? Yes No
b. If you are sexually active:
 - ~ Do you avoid sexual activity because of pain?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ Do your bladder problems (leakage or fear of leakage of urine) affect your sexual function?
 None of the time Rarely Once in a while Often Most of the time All of the time
 - ~ Does your prolapse (feeling a bulge in your vagina or that something is falling out from your vagina) affect your sexual function?
 None of the time Rarely Once in a while Often Most of the time All of the time