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