

DOVER WOMEN'S HEALTH      NAME \_\_\_\_\_ Todays date \_\_\_\_\_  
700 CENTRAL AVENUE  
DOVER NH 03820      Date of birth \_\_\_\_\_ Referring Physician or Primary Care \_\_\_\_\_

**Urologic Questionnaire**

1. How many deliveries have you had? Vaginal \_\_\_\_\_ Cesarean \_\_\_\_\_
2. Previous surgeries \_\_\_\_\_  
\_\_\_\_\_
3. How long have your symptoms been present? \_\_\_\_\_
4. Do you lose urine during coughing, sneezing, laughing or lifting? Yes No
5. Do you ever have an extremely severe urge to urinate? Yes No
6. If you answered yes to number 5, do you ever leak before reaching the toilet? Yes No
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? Yes No
8. How many times during the day do you urinate? \_\_\_\_\_
9. How many times do you urinate during the night after going to bed? \_\_\_\_\_
10. Are you sexually active? Yes No
11. Do/Did you ever leak during sexual intercourse? Yes No
12. Do you find it necessary to wear a pad or panty liner because of you leaking? Yes No
13. How often do you leak? \_\_\_\_\_
14. Have you ever had treatment for kidney disease, infection, tumor, or injuries, or stones ? Yes No
15. Do you have pain or discomfort when you urinate? Yes No
16. Is your urine ever bloody? Yes No
17. Do you find it hard to begin to urinate? Yes No
18. Do you have a slow urinary system? Yes No
19. Do you ever have to strain to pass your urine? Yes No
20. After you urinate, do you have dribbling or feel like your bladder is still full? Yes No
21. Do you smoke? Yes No
22. Do you drink caffeine products? (coffee, tea, soda) Yes No      If yes, how much \_\_\_\_\_
23. Do you have glaucoma? Yes No
24. Have you had liver disease? Yes No