FEMALE INCONTINENCE QUESTIONNAIRE

Patient Name_____Date_____

Do you have leakage with:

Coughing or sneezing?	Yes_____ No_____
Lifting?	Yes_____ No_____
Active exercise? (running, intercourse, etc)	Yes_____ No_____
Minimal exercise? (Walking, light housework, etc)	Yes_____ No_____
Sleeping?	Yes_____ No_____
Nervousness or increased anxiety?	Yes_____ No_____
Leakage unrelated to any cause?	Yes_____ No_____

Is your clothing Damp _____Wet _____or Soaking Wet? _____

For protection do you use: Kotex Pads_____ Tissue _____or Diapers? _____

How many protective pads do you use per day? _____
Are they Damp _____ Wet _____ or saturated _____ at each change?

Do you leave puddles of urine on the floor?	Yes _____ No_____
Do you lose urine by continuous dribbling?	Yes _____ No_____
Do you lose urine in small spurts?	Yes _____ No_____
If yes, is it related to physical activity	Yes _____ No_____
When you have the desire to urinate, do you lose urine before you can get to the toilet?	Yes _____ No_____
Do you get severe urge:	
In the cold weather?	Yes _____ No_____
With running water?	Yes _____ No_____
At the front door of your home or restroom?	Yes _____ No_____
Do you have pain over your bladder when you are full Or get the strong urge?	Yes _____ No_____

How often do you pass urine during the day?
Every hour or less _____1-2 hours _____2-3 hours,_____,3-4 hours or greater than 4 hours_____

How often do you pass urine after going to bed? _____
Is the volume of urine you pass usually?
Large_____ average _____small_____ or very small_____

Do you empty your bladder frequently, before you experience the desire to pass urine just so that you will stay dry? Yes_____ No_____

Please describe in your own word any additional information regarding your leakage problem not asked above?

_____

_____

_____

IUPUI Health Services
URINARY TRACT INFECTION QUESTIONNAIRE

Name:_____ **Today's Date:** _____
Allergies:_____ **Date of Birth:** _____
Temp: _____ **B/P:** _____ **P:** _____ **Wt:** _____ **Height:** _____

Please answer questions 1 through 8:

1. **Please circle the symptoms you are experiencing. (& explain if space) question):**
   - **Frequency:** How many times an hour do you urinate? _____
   - **Dysuria:** (Burning or pain on urination)
   - **Hematuria:** (Blood in urine)
   - **Urgency:** (sudden need to urinate)
   - **Nocturia:** (awakening during sleep to urinate) How many times during your sleep?_____
   - **Incontinence:** (loss of control)
   - **Back pain:** if yes, right side, left side or both?_____
   - **Fever:** if yes, highest temp_____ for how many days? ___
2. **How long (days) have you had these symptoms?**_____
3. **Have you had a previous urinary tract infection(UTI)?** Yes No
   If yes, more than 2 per year? Yes No
   Please list medication taken for past UTI:_____
4. **Have you ever had an infection of the kidney?** Yes No
5. **Have you taken any medication for current symptoms?** Yes No
   List all prescription, over the counter medication, or herbs that you have taken in the last 2 days:_____
6. **Females only: when did your last menstrual cycle begin?**_____
7. **Do you drink caffeinated beverages? (soft drinks/coffee/tea)** Yes No
   if yes, how many ounces per day? _____
8. **Are you sexually active?** Yes No
   If yes, when did you last have sex? _____

Urinalysis results: Color:_____ **Turbidity:**_____ **pH:**_____ **Sp. Gr.:**_____
Labstix results:_____

Reviewed by (nurse):_____

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER:

Notes:_____
Microscopy results:_____
Tests ordered: U/A with micro C&S CBC w/diff w/o diff _____
RX/Plan:_____

_____
Physician/Nurse Practitioner Signature

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