Instructions for Bladder Diary

This diary will help us figure our why you have trouble holding you urine, or why you go to the bathroom very often. Keep this diary for at least one full day. Two days of recordings is better.

You should write down 4 things every time you pass or leak urine:

1. The time (for instance, "10:30 AM")
2. The amount of urine that you pass.
3. Whether you leaked any urine (were "wet") or not (were "dry")
4. Whether anything special may have caused you to go (for instance, "just had coffee", "coughed", "was running to the bathroom", "just took my water pill".

Measure the amount of urine you pass: Use a measuring cup, and write down the amount of urine in ounces. If you leak and cannot measure the amount that came out, write down your best guess. Start the record in the morning, with the first time you go to the bathroom after you get up.

Thank you for your help!

John M Garofalo, MD

Your Name_____ Start date_____

TIME	AMOUNT OF URINE PASSED	LEAKED URINE (WET) OR NOT (DRY)	ANYTHING SPECIAL THAT MAY HAVE CAUSED YOU TO GO

Your Name_____ Start date_____

TIME	AMOUNT OF URINE PASSED	LEAKED URINE (WET) OR NOT (DRY)	ANYTHING SPECIAL THAT MAY HAVE CAUSED YOU TO GO

Incontinence Symptom Questionnaire

Last Name _____ First Name _____ Middle Initial _____ Telephone _____

Address _____ City _____ State _____ ZIP _____ E-mail Address _____

Instructions: Please answer the following questions about your urine (water) leakage. When you return the completed form, we will examine the information you've recorded and discuss it with you.

1. How long have you leaked urine? _____

2. Since you began leaking urine, has the amount you leak each time:
   ❑ Increased ❑ Decreased ❑ Stayed the same

3. Has the number of times you have leaked urine each day, week, or month:
   ❑ Increased ❑ Decreased ❑ Stayed the same

4. Please place a check next to the word that best describes how often each of the following activities causes you to leak urine.

	Never	Sometimes	Often
a) Exercising, including running and participating in other high-impact sports	❑	❑	❑
b) Sneezing	❑	❑	❑
c) Coughing	❑	❑	❑
d) Laughing	❑	❑	❑
e) Lifting	❑	❑	❑
f) Changing position from sitting or standing up	❑	❑	❑
g) Bending down	❑	❑	❑
h) Reaching	❑	❑	❑
i) Walking or rushing to the toilet	❑	❑	❑
j) Seeing or hearing running water	❑	❑	❑
k) Washing hands	❑	❑	❑
l) Feeling nervous or stressed	❑	❑	❑
m) Being out in cold weather	❑	❑	❑
n) Unlocking the front door	❑	❑	❑

5. Do you have strong urinary urges that you cannot always control?
   ❑ Yes ❑ No

6. Once your bladder feels full, how long can you hold your urine?
   ❑ As long as I want
   ❑ Less than a minute
   ❑ A few minutes
   ❑ Cannot tell when bladder is full

7. How often do you leak urine?
   ❑ Once a week at most ❑ 2 or 3 times a week
   ❑ About once a day ❑ Several times a day
   ❑ Continuously

8. When does the leakage occur?
   ❑ Mainly during the day ❑ Mainly at night
   ❑ Both day and night

9. Do you ever find yourself wet or damp without realizing that you've leaked urine?
   ❑ Never ❑ Sometimes ❑ Always

10. Do you wake up in the night to urinate?
    ❑ Never or rarely ❑ 2-3 times per week
    ❑ Almost every night ❑ 1 time per night
    ❑ 2 times per night ❑ 3 or more times per night

11. Please indicate how much urine you usually leak.
    ❑ A small amount (leaves you slightly damp)
    ❑ A moderate amount (1 or 2 tablespoons)
    ❑ A large amount (more than 2 tablespoons)

12. How much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 5 (a great deal).
    0 1 2 3 4 5

13. If you avoid any of the following activities because you might leak urine, please check them below.
    ❑ Exercising ❑ Playing sports
    ❑ Dancing ❑ Traveling
    ❑ Dating ❑ Shopping
    ❑ Working outside the home ❑ Having sex

14. Has urine leakage stopped you from doing any of the above activities during the past 5-10 years? If so, please list those activities below.

_____

_____

_____

_____

Last Name First Name Middle Initial

15. Please check anything listed below that has occurred when you urinate.

- ❑ Difficulty in getting urine started
- ❑ Very slow stream or dribbling
- ❑ Discomfort, burning, or pain
- ❑ Blood in the urine
- ❑ Feeling that your bladder did not empty completely
- ❑ Loss of urine in sudden, large amounts
- ❑ Stopping and starting urine stream
- ❑ Urinate, stand up, urinate again to empty your bladder
- ❑ Lose urine as you walk away from the toilet

16. Did you wet the bed as a child?

❑ Yes ❑ No

If so, until what age? _____ How often? _____

17. If you have been treated for bladder leakage, urgency, or frequency before, please check all of the treatments that you have received in the past.

- ❑ Acupuncture
- ❑ Surgery
- ❑ Medications
- ❑ Pelvic muscle exercises
- ❑ Electrical stimulation
- ❑ Bladder training
- ❑ Biofeedback
- ❑ Collagen injections
- ❑ Urethral inserts/incontinence pessaries
- ❑ Other treatments? Please list them below.

_____

_____

18. In the chart below, please place a check next to the medications you have used or are currently using to treat incontinence, and indicate whether or not they have improved your condition.

Medication	Used (√)	Was the medication helpful?	
Detrol® (tolterodine)	❑	❑ Yes	❑ No
Ditropan® (oxybutynin)	❑	❑ Yes	❑ No
Levsin®, Levsinex®, Cystospaz® (hyoscyamine)	❑	❑ Yes	❑ No
Tofranil® (imipramine)	❑	❑ Yes	❑ No
Pro-Banthine® (propantheline)	❑	❑ Yes	❑ No
Urispas® (flavoxate)	❑	❑ Yes	❑ No
Ornade® (chlorpheniramine and phenylpropanolamine)	❑	❑ Yes	❑ No
Sudafed® (pseudoephedrine)	❑	❑ Yes	❑ No
DDAVP® (desmopressin)	❑	❑ Yes	❑ No
Oxytol Patch	❑	❑ Yes	❑ No
Other(s)	❑	❑ Yes	❑ No

19. Have you ever had to use a catheter to drain your bladder?

❑ Yes ❑ No

20. Please check all of the "self-help" techniques you have used to deal with urine leakage.

- ❑ Wear panty liners
- ❑ Wear sanitary napkins or incontinence pads
- ❑ Wear adult pads or briefs designed for urine control
- ❑ Wear other protective underclothes
- ❑ Put toilet paper/paper towels inside briefs
- ❑ Drink less fluids
- ❑ Go to the toilet often
- ❑ Stay near a bathroom
- ❑ Use a bedside commode or bedpan

21. Have you used any other self-help techniques? Please list them below.

_____

_____

_____

22. How often do you have a bowel movement?

- ❑ Once a day
- ❑ More than once a day
- ❑ 2-3 times a week
- ❑ Less than once a week

23. If you have had any of the problems listed below, please check them.

- ❑ Straining on more than 1 out of 4 bowel movements
- ❑ Using enemas or laxatives (not fiber or bulk) to relieve constipation more than once a month
- ❑ Diarrhea (how often? _____)
- ❑ Bloody stool
- ❑ Change in the pattern of your bowel movements over the past year
- ❑ Uncontrolled loss of stool

24. a) Are you sexually active now?

❑ Yes ❑ No

b) If so, do you have trouble/pain urinating after intercourse?

❑ Yes ❑ No

c) Do you have discomfort/pain with intercourse?

❑ Yes ❑ No

25. What changes would you like to see in your symptoms as a result of your treatment here?

_____

_____

_____

Thank you for completing this form.

Reviewed by Clinician: _____ Date: _____