

Patient Name: _____ DOB: _____

Which symptoms best describe you? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Frequent urination (day, night, or both) | <input type="checkbox"/> Leaking with urge or no warning
(unable to make it to the restroom in time) |
| <input type="checkbox"/> Sudden or strong urge to urinate | <input type="checkbox"/> Bladder or pelvic pain |
| <input type="checkbox"/> Unable to empty bladder fully | <input type="checkbox"/> None of the above
(if checked, you are finished with this questionnaire) |
| <input type="checkbox"/> Leaking with sneezing, coughing, or exercising | |

How long have you been experiencing these symptoms? _____

Have you tried any medication to help with these symptoms? Yes No

Check all the medications you have tried:

- | | | | | |
|--|-----------------------------------|------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Detrol LA | <input type="checkbox"/> Vesicare | <input type="checkbox"/> Elavil | <input type="checkbox"/> Ditropan XL | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Oxytrol Patch | <input type="checkbox"/> DDAVP | <input type="checkbox"/> Myrbetriq | <input type="checkbox"/> Flomax | _____ |
| <input type="checkbox"/> Enablex | <input type="checkbox"/> Sanctura | <input type="checkbox"/> Elmiron | <input type="checkbox"/> Cardura | _____ |

Have these medications helped? (Circle best answer)

No relief **Relief:** 1 2 3 4 5 6 7 8 9 10 Total

Are you still take these medications? Yes No

If not, why did you stop? Did not help Side effects Too expensive

What is your level of frustration with your bladder symptoms? (Circle best answer)

Not Frustrated Very Frustrated

1 2 3 4 5 6 7 8 9 10

Do you currently have problems with bowel function? Yes No

If yes, please describe. Constipation Diarrhea Bowel Incontinence Other: _____

Would you be interested in treatment options for your bladder symptoms other than medication? Yes No

SPECIFIC CONSENT FOR GENITAL OR PELVIC EXAMINATION

I, specifically consent, to have a genital examination performed on me if my urology provider so recommends. For males, this consent includes an examination of the external genitals and the prostate gland; for females, this consent includes a pelvic examination: the external genital and the internal genitalia (vagina, cervix, uterus, fallopian tubes, ovaries, and rectum).

Signature of Patient: _____ Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative: _____ Date: _____