urological associates inc.

ST. MARY'S MEDICAL GROUP

Name____ Date__________________________________

FEMALE QUESTIONNAIRE

1. **Incomplete Emptying**

   Do you feel like after you urinate you are still holding urine in your bladder? O Yes O No

2. **Frequency**

   Do you have to urinate more than every 2 hours? O Yes O No

3. **Incontinence**

   Do you wet yourself when sneezing or coughing? O Yes O No

   Do you wet yourself without knowing it? O Yes O No

   How many pads do you wear per day?

   O 0 O 1 O 2 O 3 O 4 or more

4. **Urgency**

   Do you wet yourself if you don't get to the restroom on time? O Yes O No

5. **Dysuria**

   Do you have pain or burning while urinating? O Yes O No

6. **Straining**

   Do you have to push or strain to begin urinating? O Yes O No

7. **Weak**

   Is your stream weak or slow? O Yes O No

8. **Intermittency**

   Does your stream stop and start again while urinating? O Yes O No

9. **Nocturia**

   Do you get up at night to urinate? O Yes O No

   If yes, how many times is average for you?

   O 1 O 2 O 3 O 4 O 5 or more