Urinary Incontinence Assessment Sheet

Name _______________________   Allergies _________________________
Date of Birth ______________________   Date of Visit _______________________
Reviewed by _________________________

<table>
<thead>
<tr>
<th>Urinary Stress Incontinence</th>
<th>Not at All</th>
<th>Less than 1 time in 5</th>
<th>Less than ½ the time</th>
<th>About ½ the time</th>
<th>More than ½ the time</th>
<th>Almost Always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urinary Urgency Incontinence</th>
<th>Not at All</th>
<th>Less than 1 time in 5</th>
<th>Less than ½ the time</th>
<th>About ½ the time</th>
<th>More than ½ the time</th>
<th>Almost Always</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

If you have experienced an involuntary loss of urine, please answer the following questions.

When did you first experience urinary incontinence? _________________________________

Do you use pads to control your urinary leakage? No __Yes __ (type ___________, # of pads daily __; damp __ soaked __)

If you have both stress and urgency urinary incontinence, which type bothers you the most? Stress ___ Urgency ____

Have you experienced any skin irritation as a result of urinary incontinence? No __ Yes ___

Diet and Lifestyle:
1. How much fluid (ounces) do you drink in 24 hours? __________
2. What type of fluid do you drink? __________________________________________________________________
3. Have you ever smoked, or are you currently smoking? Never __ No __ (quit ____) Yes __ (pk/day _____, yrs smoking _____)
4. If you have gained weight, have your symptoms worsened since you gained weight? No __ Yes __

Past history:
Have you given birth? No __ Yes ___  (# children ____/ type of delivery: vaginal ___ cesarean ___)

Do you have a constipation problem? No __ Yes __

Have you ever had any surgery to correct urinary leakage? No __ Yes __ (explain _________________________________)

Have you taken any medications to treat urinary leakage? No __ Yes __ (explain _________________________________)

Have the medications helped? No __ Yes ___

Have you ever had a urinary tract infection? No __ Yes __ (how often? _________________________________)

Have you tried any other treatments to improve urinary control? No __ Yes __ (explain _________________________________)

Quality of Life Due to Urinary Incontinence

If you were to spend the rest of your life with your urinary incontinence just the way it is now, how would you feel about it?