

CONTINENCE CONTROL QUESTIONNAIRE

Name:

Physician:

Date:

1. Please describe your main problem _____

2. When did it begin? _____ Is it getting better, worse or no change? (circle one)

3. Please describe activities or things that you cannot do because of your problem _____

4. Please list all pelvic and abdominal surgeries, including birthing procedures _____

5. Date of last pelvic examination _____ Date of last urinalysis _____

Have special tests been performed? Y N Date(s) performed _____

If so, what type? _____

6. OCCURRENCE OF INCONTINENCE OR LEAKAGE

(If not applicable, go to question 12)

Never₆

Less than 1/month₅

More than 1/month₄

Less than 1/week₃

More than 1/week₂

Almost every day₁

More than 1/day₀

7. PROTECTION WORN

No protection₅

Pantishields₄

Mini Pad₃

Maxi Pad₂

Incontinence Pad₁

Incontinence Brief₀

8. SEVERITY

No leakage₃

Few drops₂

Wet underwear₁

Wet outerwear₀

9. ACTIVITY THAT CAUSES URINE LOSS

- Vigorous activity₃
- Moderate activity₂
- Light activity₁
- No activity₀

10. POSITION(S) IN WHICH LEAKAGE OCCURS

- Lying down
- Sitting
- Standing
- Changing positions (e.g. moving from sit to stand)
- Intercourse
- Strong urge

11. HOW LONG CAN YOU DELAY THE NEED TO URINATE?

- Indefinitely₆
- 1+ hours₅
- ½ hour₄
- 15 minutes₃
- Less than 10 minutes₂
- 1-2 minutes₁
- Not at all₀

12. DO YOU HAVE PELVIC PRESSURE OR A “FALLING OUT” FEELING?

- Never₅
- Occasionally/during menses₄
- At the end of the day₃
- With straining₂
- With standing₁
- Pressure all day₀

13. DAYTIME URINATION FREQUENCY

- 1-4 times per day₀
- 5-8₀
- 9-12₁
- 13+₂

14. NIGHTTIME FREQUENCY

- 0 times per night₀
- 1 time per night₀
- 2₁
- 3₂
- 4+₃

15. FLUID INTAKE

- 9+ 8 oz glasses per day
- 6-8 8oz
- 3-5 8oz
- 1-2 8oz
- # of caffeinated glasses _____

16. FREQUENCY OF BOWEL MOVEMENTS

- 2 times per day
- 1 times a day
- every other day
- once every 4-7 days

17. AFTER STARTING TO URINATE, CAN YOU COMPLETELY STOP THE URINE FLOW?

- Can stop completely₃
- Can maintain a deflection of the stream₂
- Can briefly deflect the stream₁
- Unable to deflect or stop the stream₀

18. DO YOU HAVE TROUBLE INITIATING A URINE STREAM?

- Never₃
- More than once a month₂
- More than once a week₁
- Every day

19. HOW MUCH OF A PROBLEM FOR YOU ARE YOUR SYMPTOMS?

- No problem₄
- Minor inconvenience₃
- Slight problem₂
- Moderate problem₁
- Severe problem₀

20. Are you sexually active? Y N

Are you pregnant or attempting pregnancy? Y N

Number of pregnancies _____ Number of deliveries _____

Complications? _____

21. Do you have or have you ever had a sexually transmitted disease? Y N

Type _____

22. Do you have pain or problems with urination or intercourse? Y N

If so, describe _____

23. Have you ever been taught how to do pelvic floor or Kegel exercises? Y N

If so, when? _____ By whom? _____

24. How often do you do pelvic floor exercises? _____

25. Has your doctor prescribed any medication to treat urine loss? Y N

If so, what medication(s)? _____

26. Any comments or concerns not addressed in this questionnaire? _____
