Lancaster Urology
Incontinence Patient Profile

Name:_____ Date:___/___/_____

Instructions: Please answer each question below by making a checkmark (✓) In the appropriate box. Bring this form with you to your first appointment.

1. How long have you had a problem with urinary leakage (incontinence)?
   - ☐ 1 week to 3 months
   - ☐ 3 to 12 months
   - ☐ 1 to 5 years
   - ☐ 5 to 10 years
   - ☐ More than 10 years

2. Did the urine leakage
   - ☐ Begin suddenly
   - ☐ Develop gradually over time

3. How often do you lose urine/water during a typical week?
   - ☐ Less than once a week
   - ☐ Once a week
   - ☐ More than once a week
   - ☐ Once a day
   - ☐ More than once a day

4. When does the leakage occur?
   - ☐ Mainly during the day
   - ☐ Mainly at night
   - ☐ Both day and night

5. When you leak/lose, how much do you leak?
   - ☐ Damp/a few drops
   - ☐ Wet enough to wet underpants
   - ☐ Quite wet, a cupful (soak pads/other protection)

6. When your bladder feels full, how long can you hold your urine?
   - ☐ Less than a minute or two
   - ☐ Just a few minutes
   - ☐ More than a few minutes
   - ☐ Cannot tell if bladder is full

7. Do you experience urinary leakage during any of the following?
   - ☐ coughing
   - ☐ sneezing
   - ☐ laughing
   - ☐ lifting heavy objects
   - ☐ On the way to the bathroom
   - ☐ "key in door" when trying to open door
   - ☐ sleeping
   - ☐ active exercise
   - ☐ changing position
   - ☐ nervousness
   - ☐ rushing
   - ☐ running water
   - ☐ cold weather
   - ☐ continual leakage
   - ☐ dribbling after urination
   - ☐ walking
   - ☐ without being aware
   - ☐ other: _____

8. Do you have strong urinary urges you cannot always control?
   - ☐ Yes
   - ☐ No, never

9. Do you have trouble getting to the toilet in time?
   - ☐ Yes
   - ☐ No, never

10. How often do you urinate during the day?
    - ☐ More than every hour
    - ☐ About every 1-2 hours
    - ☐ About every 3-5 hours
    - ☐ Frequency varies
    - ☐ Unknown

11. Do you wake up a night to urinate?
☐ Never ☐ About 1 to 2 times
☐ 3 or more times

12. When urinating, do you experience
☐ problem starting stream ☐ weak, slow stream/dribbling
☐ pain ☐ discomfort
☐ burning ☐ blood in urine
☐ loss of urine in sudden large amounts ☐ bladder not emptying fully
☐ stopping and starting urine stream ☐ None of the above

13. Do you use any of the following for protection during urinary leakage?
☐ panty liner ☐ sanitary napkins – feminine hygiene pads ☐ guards for men
☐ minipads
☐ adult briefs/diapers ☐ under garments (with straps with straps and buttons ☐ protective underwear - disposable
☐ larger pads in underwear
☐ homemade pads, tissues ☐ bed or furniture pads ☐ cloth garments
☐ bedside commode/urinal
☐ other:_____

14. How many times per day do you need to change pads or other products?
☐ 1 or fewer ☐ 3 ☐ 5
☐ 2 ☐ 4 ☐ 6 or more

15. Have you ever seen a urologist or other doctor for your problem?
☐ yes ☐ no
Name (if yes): _____
What did he/she do? _____

16. Are you avoiding certain activities because of a urine loss problem?
☐ yes ☐no

17. Are you sexually active now?
☐ No ☐ Yes (answer A, B, and C)
A. Do you have difficulty with urination after intercourse? ☐ Yes ☐ No
B. Do you have pain/discomfort with intercourse? ☐ Yes ☐ No
C. Do you ever leak/lose urine during intercourse? ☐ Yes ☐ No

18. For men: are you having problems with impotence and maintaining an erection for intercourse?
☐ Yes ☐ No

19. How often do you have a bowel movement?
☐ Once a day ☐ 2-3 times a week
☐ More than one per day ☐ Less than 1 time a week

20. Do you have any of the following:
☐ constipation ☐ diarrhea
☐ bloody stools ☐ bowel incontinence
☐ none of the above

21. Do you use laxatives?
☐ no ☐ Yes (which ones?) Describe _____

22. Do you ever lose control of your bowels?
☐ no ☐ Yes Describe _____

23. Has there been a change in the pattern of your bowel movements in the past year?
☐ Yes ☐ No

24. Have you previously tried pelvic muscle exercises or Kegel exercises?
☐ Yes ☐ No
If yes, describe how you have done them. _____
_____

25. Do you drink alcohol? ☐ Yes ☐ No
If yes, indicate number of glasses per week:
_____ beer (glasses) _____ wine (glasses) _____ spirits (glasses)

26. Indicate what amount you drink of the following in a typical day:
_____ Water (8 oz. glasses) _____ Coffee (cups) _____ Tea (cups)
_____ Juice (8 oz. glasses) _____ Soda (8 oz. glasses)

27. Do you have trouble with:

Feeling of tingling or numbness in any parts of your body	☐ Yes	☐ No
Weakness in your arms and legs	☐ Yes	☐ No
Weakness of one side of your body	☐ Yes	☐ No

28. Please check the appropriate box/boxes if you use any of the following:
☐ Cane ☐ Wheelchair ☐ Walker

Urological Review – Men and Women	
Prior Genitourinary history:	
☐ hysterectomy ____ year ☐ vaginal ☐ abdominal ☐ ovaries removed ☐ Urethral stricture/dilatation ☐ Discharge – genital area ☐ Urinary tract infection – date and type: _____ ☐ Itching/odor – genital area/vagina	☐ Bladder tumor ☐ Bladder surgery ☐ Pelvic radiation ☐ Prostatitis/BPH ☐ Prostate cancer ☐ Collagen Injections ☐ Other – specify _____

Gynecological Review – Women Only	
Gynecological Review: Prolapse: ☐ bladder ☐ uterus ☐ rectum Menstrual cycle information: _____ Date of last period _____ Date of last pap smear	Pregnancy and childbirth information: Use of: ☐ Pessary ☐ IUD ☐ Diaphragm ☐ Birth control Specify_____ _____ # of pregnancies _____ # of vaginal deliveries _____ # of Cesarean sections _____ # of episiotomies

Previous surgery: _____

Reviewed by: _____ Date: _____