FEMALE REVIEW OF SYMPTOMS

Do you now or have you had any recent problems related to the following systems? Circle **Yes** or **No**.

Urinary Incontinence (urine leakage) symptoms

Excessive urge to urinate Y N
Excessive frequency of urination Y N
How many times do you urinate in 24 hours _____

Leaking with cough, laugh, movement? Y N
Leaking with urgency (can't get to toilet in time) Y N

Do you wear pads due to leaking Y N
How many in 24 hours:_____
What kind/type:_____

How often do you experience leakage (circle)?
- Never
- Less than once monthly
- A few times a month
- A few times a week
- Every day and/or night

How much urine do you lose each time (circle)?
- None, I do not leak
- Drops
- Small splashes
- More

When you have the urge to urinate, how long can you delay?___seconds___minutes___hours___not at all

Average fluid intake per day (1 glass is 8oz/1cup) _____glasses/day
How many cups of caffeinated beverages per day? _____glasses/day

Circle any foods/drinks you commonly enjoy:

Coffee Tea Cola Soda Spicy Foods Citrus Fruits/Juice (orange, lemon, etc) Tomato MSG
Artificial sweeteners Alcohol Chocolate Pickled Foods Indian/Mexican/Thai foods

Pain

Describe the pain_____

With urination Y N
Relieved by urination Y N

Pelvic Organ Prolapse symptoms

Pressure in lower abdomen Y N
Heaviness/Dullness in the pelvis Y N
Sensation of incomplete emptying? Y N

Have to push on a vaginal bulge to start or complete urination Y N

Bulge or something falling out that you can see or feel in the vaginal area Y N
Have to push on the vagina or around the rectum to have or complete a bowel movement Y N

Other _____

Office use only
_____Date Physician signature_____