Please complete this voiding diary and questionnaire. Bring both of them with you to your next appointment with your provider.

To begin the diary, please choose two days when you will be at home. The two days do not need to be consecutive. Fill in your diary for two 24-hour periods; start upon awakening and include nighttime. You will be recording all liquid intake and output. Please remember to include the type of beverage you are drinking, such as decaf or regular coffee, decaf or regular diet soda. Reviewing the enclosed example diary should help clear up questions, or you can call us to discuss.

We have urine collection hats available at our office for your convenience. If you are unable to get a measuring hat, a large measuring cup will work.

If we are seeing you for a prolapse problem, you may not be experiencing any urinary incontinence; however, the diary will be helpful in discerning any abnormal bladder behavior.

If you find that you are unable to keep your appointment, please contact our office at least 24 hours in advance so that we may arrange a more convenient time. When we have advance notice of cancellations, we can arrange to see other patients in your absence. We appreciate your assistance in helping us provide a high quality of care to all of our patients.

Sincerely,

Providence Medical Group
OB/GYN Health Center providers
INCONTINENCE QUESTIONNAIRE

Name: ________________________________     Date: ___________________

Date of birth: _______________________

Please describe your current urinary problem:
________________________________________________________________
________________________________________________________________

When did this begin? ____________________________________________

Was this after surgery? ___After delivery? ___After menopause? ___

**Stress incontinence:**
Do you leak when you cough, sneeze, laugh or lift? Yes____ No____
Do you lose urine while walking or running? Yes____ No____
Do you lose urine while lying down? Yes____ No____
How often does this happen? ______________________________________

**Urge incontinence:**
Do you ever have such a strong need to urinate that if you don’t reach the toilet you leak? Yes____ No____
Do you ever leak before reaching the toilet? Yes____ No____
How often? __________________________
Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? __________________________

**Nocturia:**
How often do you usually urinate during the night? __________
Does the sense of urgency to void awaken you? Yes____ No____
Do you awaken because of feeling wet? Yes____ No____
Do you leak enroute to the bathroom? Yes____ No____
Have you wet the bed in the last year? Yes____ No____

**General:**
How many times do you urinate during the day? _________________________
Is the volume small, medium, or large? ____________________________

Updated 12-9-09
What are your most common beverages? _______________________________
How many liquid ounces do you drink a day? ____________________________
Did you wet the bed as a child? Until what age? _________________________
Do you leak with sexual intercourse? _________________________________
How long have you worn a pad? ______________________________________
What type of pad do you wear? _______________________________________
How many pads do you use during the day? How many at night? _________
When you change pads, are the pads damp, wet or soaked?_______________
Have you ever had bladder or kidney infections? Yes____ No____
Are you troubled by pain when your bladder is full? Yes___ No____
Are you troubled by pain when you urinate? Yes___ No____
Have you had blood in your urine? Yes___ No____
Do you find it hard to begin urinating? Yes___ No____
Do you ever have a slow urine stream? Yes___ No____
Do you ever need to strain to pass urine? Yes___ No____
After you urinate, do you dribble? Yes___ No____
After urinating, do you feel your bladder is not empty? Yes___ No____
Do you ever find that you have leaked without a triggering event such as a urge
or cough? Yes___ No____
Have you had prior treatment for urinary incontinence? Yes___ No____
If yes, please circle each one that applies:
Behavioral: Kegel exercises, pelvic floor muscle exercise, biofeedback, electrical
stimulation, bladder retraining drills
Medications:_______________________________________________________
Surgery: _________________________________________________________

Bowel function:
How often do you have a bowel movement? ____________________________
Do you have problems with constipation? Yes___ No____
What do you do for this? ____________________________________________
Do you have problems with diarrhea or loose stools? Yes___ No____
Do you sense of incomplete emptying of the rectum? Yes___ No____
Do you need to use vaginal pressure to empty the rectum? Yes___ No____
Do you need to strain to pass stool? Yes___ No____
Do you need to return to the toilet multiple times to empty? Yes___ No____
Do you ever lose control of stool? Yes___ No____
Is this with gas, liquid or solid? ______________________________________
Is this preceded by urgency to defecate? Yes___ No____
How often does this happen? _______________________________________

Personal Impact of your Incontinence, please be specific
What is the most distressing symptom?
________________________________________________________________
________________________________________________________________
How has it limited your activity?
________________________________________________________________
________________________________________________________________

Updated 12-9-09
What have you stopped doing that you enjoyed because of the incontinence?
________________________________________________________________________
________________________________________________________________________

What is your goal in treatment?
________________________________________________________________________
________________________________________________________________________
Filling in your voiding diary
Choose two 24-hour periods when it will be convenient for you to complete the diary. Start upon awakening and include nighttime. You will need a urine collection hat or a measuring cup to begin.

You will be recording the following data:
- The time, type and amount of fluid you drink. (Regular or decaf coffee, water, caffeinated or non-caffeinated soda, diet soda, regular or herbal tea, etc.)
- The time and amount of your void (urination), any urge sensation and your activity.
- The time and amount of any leaking episode, any urge sensation and your activity.
- If you are simply voiding because you are about to leave home, please record that as well.

SAMPLE

<table>
<thead>
<tr>
<th>Time</th>
<th>Fluid intake type &amp; ounces</th>
<th>Void amount (ounces)</th>
<th>Leak: Small Medium Large</th>
<th>Urge?</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:30 a.m.</td>
<td>12 oz.</td>
<td>no</td>
<td>no</td>
<td>waking up</td>
<td></td>
</tr>
<tr>
<td>7 a.m.</td>
<td>Coffee, reg. 10 oz.</td>
<td>7:20 a.m.</td>
<td>4 oz.</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>8 a.m.</td>
<td>coffee, decaf 8 oz.</td>
<td>8:45 a.m.</td>
<td>small</td>
<td>no</td>
<td>coughing</td>
</tr>
<tr>
<td>9:30 a.m.</td>
<td>8 oz.</td>
<td>no</td>
<td>no</td>
<td>leaving home</td>
<td></td>
</tr>
</tbody>
</table>

Updated 12-9-09
# Voiding diary

<table>
<thead>
<tr>
<th>Time</th>
<th>Fluid intake &amp; ounces</th>
<th>Time</th>
<th>Void amount (Ounces)</th>
<th>Leak: Small</th>
<th>Medium</th>
<th>Large</th>
<th>Urge?</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Fluid intake &amp; ounces</td>
<td>Time</td>
<td>Void amount (Ounces)</td>
<td>Leak: Small</td>
<td>Medium</td>
<td>Large</td>
<td>Urge?</td>
<td>Activity</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------</td>
<td>------</td>
<td>----------------------</td>
<td>-------------</td>
<td>--------</td>
<td>-------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>