Yitzhack Asulin, M.D.
Obstetrics and Gynecology

Urinary Incontinence Questionnaire

This questionnaire will help us to determine what are the causes of your problem with urination. Please think about how your problems with urination have affected you over the last month or two as you answer each question.

Name _____ Age _____ Date _____

1. Have you ever experienced any involuntary leakage of urine? ❒No ❒Yes
2. Does the loss of urine ever keep you from leaving your home or participating in social events? ❒No ❒Yes
3. Do you ever have to schedule trips, social events, or errands around your toileting schedule? ❒No ❒Yes
4. Did you ever have to change your intake of fluids to avoid accidents? ❒No ❒Yes
5. Do you find that you must use special pads to protect yourself case you do leak urine? ❒No ❒Yes
6. Have you ever noticed blood in your urine or staining the toilet water, when you urinate? ❒No ❒Yes
7. Do you have any burning or pain when you pass urine? ❒No ❒Yes
8. How often do you urinate during the daytime hours? ❒ 1-2 times ❒ 3-5 times ❒ More than 5 times
9. How many times do you get up to urinate at night? ❒ 1-2 times ❒ 3-5 times ❒ More than 5 times
10. When you try to urinate, does it take you a long time to get started? ❒No ❒Yes
11. Is your urinary stream as strong as it ever was? ❒No ❒Yes
12. Do you ever leak urine upon coughing, sneezing, laughing, or when you stand up? ❒No ❒Yes
13. Can you stop urinating after you have started? ❒No ❒Yes
14. best describes how quickly you must get to the bathroom after you experience the urge to urinate

❒ Right away ❒ I can wait, but a very short time ❒ I can wait until it is convenient

Reviewed by _____