

BLADDER AND BOWEL SYMPTOM QUESTIONNAIRE

me:_	Date:
1.	How often do you urinate during the day?times, at night?times.
2.	How often do you have a bowel movement?times/day/week?
3.	How often do you experience bowel/bladder leakeage?
	□ Never □ less than daily □ daily □ throughout day □ nighttime/sleep
4.	What is the amount of leakage?
	☐ No leakage ☐ soils pad or underwear ☐ soils outerwear
5.	What type of protection do you wear?
	□ None □ pantiliner □ maxipad □ specialty product □ other
	How many do you use per day?
6.	What causes you to leak? (check all that apply)
	☐ Vigorous activity (running, aerobics)
	☐ Light activity (walking, light house work)
	□ Cough/sneeze
	☐ Walking to the toilet
	☐ Strong urge to go
	☐ Intercourse or sexual activity
	□ Other
7.	How long can you delay the need to urinate?
	\square Not at all \square 1-5 min \square 5-10 min \square 10-30 min \square 30+min
8.	How much fluid do you drink each day? (one glass = 8 oz or one cup)
	total glasses of liquid per day
	# of caffeinated glasses per day
	# of alcoholic beverages per day
9.	Rate your feelings as to the severity of this problem from 0-10, 10 being the worst.
	010
	No problem major problem
Ado	ditional comments:

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Bladder Habits

1. Are you unable to stop the flow of urine when on the toilet?	Y/N	
2. Is it difficult to tell when you need to go to the toilet?		
3. Do you strain to pass urine?		
4. Do you empty your bladder before you experience the urge to urinate?	Y/N	
5. Do you have difficulty completely emptying your bladder?	Y/N	
6. Do you have difficulty initiating the stream of urine?	Y/N	
7. Do you have triggers that make you feel you can not wait to use the toilet?	Y/N	
8. Do you have pain or burning with urination?	Y/N	
9. Do you have pain or discomfort when you wipe yourself?	Y/N	
10. Do you leak more during, before or after your period?	Y/N	
Bowel Habits		
1. Are you unable to feel that you need to have a bowel movement or pass gas?	Y/N	
2. Do you strain to have a bowel movement?	Y/N	
3. Do you feel your rectum is not completely empty after a bowel movement?	Y/N	
4. Do you have difficulty initiating a bowel movement?	Y/N	
5. Do you have pain or burning with bowel movements?	Y/N	
6. Do you have a history of hemorrhoids?	Y/N	
7. Have you experienced a change in your bowel habits?	Y/N	
If 'yes', please describe		
8. Do you take anything to help you pass your stool?		
If 'yes', please list		
9. Do you have difficulty holding back gas?	Y/N	
Pelvic Floor Symptoms		
1. Are you sexually active?		
2. Do you have pain with intercourse or penetration?	Y/N	
3. Do you have pain with use of tampons?	Y/N	

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