Overactive Bladder Questionnaire

Name: ____________________________
DOB: ______________________

Symptoms (Please check all that apply)
☐ Sudden or strong urge to urinate
☐ Frequent urination (day, night, both)
☐ Unable to empty bladder (feels like there is more even after urinating)
☐ Leakage with little or no warning
☐ Accidental leakage with physical activity – exercising, sneezing, or coughing.
☐ Bladder or pelvic pain
☐ Burning before, during, or after urinating

Problems with bowel function (select all that apply)
☐ Accidental loss or leakage of stool
☐ Constipation
☐ Other
☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _______________________________
How frequently do you urinate during the daytime? _______________________
How many times do you urinate at night (Nocturia)? _______________________
Do you currently catheterize? Yes / No __________ How many times per day _______
Average number of pads used daily? ________

Which behavior modifications have you tried? (check all that apply)
☐ Reduce fluid intake
☐ Caffeine reduction
☐ Kegel exercises
☐ Physical Therapy

Do your urinary symptoms affect your activities of daily living? Yes / No _______

Please list any prior bladder procedures: _________________________________

Please indicate any medications you have tried. If none, select ‘none’.

☐ None
☐ DDAVP (Desmopressin Acetate)
☐ Detrol LA (Tolterodine Tartrate)
☐ Ditropan (Oxybutynin)
☐ Enablex (Darifenacin)
☐ Gelnique
☐ IC Medications [Elmiron, Elavil (Amitriptyline)]
☐ Myrbetriq
☐ Oxytrol
☐ Sanctura (Trospium)
☐ Toviaz (Fesoterodine Fumarate)
☐ Vesiccare (Solifenacin)

Did these medications help your symptoms? ☐ Yes ☐ No

If you stopped taking your medication(s), please indicate the reason:
☐ Did not help ☐ Side effects ☐ Too expensive ☐ Other

Please describe any side effects caused by the medication(s): __________________

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