

This information will help your doctor understand your bladder control problem.

I take these prescription medicines:

medicine: _____ dose: _____

medicine: _____ dose: _____

medicine: _____ dose: _____

I take these over-the-counter drugs (such as Tylenol, aspirin, or Maalox):

medicine: _____ dose: _____

medicine: _____ dose: _____

medicine: _____ dose: _____

If you take more medicines, please list them on a separate paper.

I started having bladder trouble

within the past few months

1 to 2 years ago

_____ years ago

Number of babies I have had: _____

Dates: _____

My periods stopped—menopause.

Date: _____

I had an operation.

Date: _____

Type of operation: _____

I recently hurt myself or have been sick.

Date: _____

Type of injury or illness: _____

I recently had a bladder—urinary tract—infection.

Date: _____

Check the ones that applies:

I smoke cigarettes. _____

I have pain or a burning feeling when I urinate. _____

I often have a really strong urge to urinate right away. _____

Sometimes my bladder feels full, even after I finish urinating. _____

I go to the bathroom often, but very little urine comes out. _____

I don't go out with friends or family because I worry about leaking urine. _____

The first thing I do at new places is check the bathroom location. _____

I worry about being put in a nursing home because of bladder control problems. _____

I have, or had, these medical problems:

cancer _____

depression _____

crippling arthritis _____

diverticulitis _____

diabetes _____

multiple sclerosis _____

interstitial cystitis _____

stroke _____

spinal cord injury _____

urinary infection _____

other _____