

**NAME:**  
**DATE OF BIRTH:**

**DATE:**

### Incontinence Questionnaire

Please answer as accurately as possible.

1. Do you leak urine when you cough, sneeze, or laugh? Yes No
2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? Yes No
3. If "yes" to No. 2, do you ever leak before you reach the toilet? Yes No
4. How many times during the day do you urinate? \_\_\_\_\_
5. How many times do you void during the night after going to bed? \_\_\_\_\_
6. Have you wet the bed in the past year? Yes No
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? Yes No
8. Do you ever leak during or after sexual intercourse? Yes No
9. Do you find it necessary to wear a pad because of your leaking? Yes No
10. How often do you leak? \_\_\_\_\_ times per day
11. Have you had bladder, urine, or kidney infections? Yes No
12. Are you troubled by pain or discomfort when you urinate? Yes No
13. Have you had blood in your urine? Yes No
14. Do you find it hard to begin urinating? Yes No
15. Do you have a slow urinary stream? Yes No
16. Do you have to strain to pass your urine? Yes No

17. After you urinate, do you have dribbling or a feeling that your bladder is still full?

Yes No