BLADDER SATISFACTION SURVEY

NAME: __________________________________________ DATE OF BIRTH: ________________ DATE: ________________

Which symptoms best describe you? (Circle one)

- Frequent urination – day, night, or both
- Leaking with sneezing, coughing, exercising
- Sudden or strong urge to urinate
- Unable to empty the bladder
- Leaking with urge or no warning
- None of these describe me
- (unable to make it to the bathroom in time)

How long have you had these symptoms: __________________________________________________

Have you tried medications to help your symptoms? Yes No

If yes, circle the medications you have tried:

- Detrol® LA
- Ditropan XL®
- Flomax®
- Cardura®
- Oxytrol® Patch
- Enablex®
- VESIcare®
- DDAVP®
- Sanctura®
- Elavil®
- Elmiron®
- Other: ______________________

Did these medications help your symptoms? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

No relief Completely cured

If you have stopped taking your medications, explain why: (Circle one)

- Did not help
- Side effects
- Too expensive

Describe side effects: _______________________________________________________________________

Behavior modifications tried: __________________________________________________________________

(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

Not frustrated Very frustrated

Do you currently have any problems with bowel function?

- Fecal incontinence
- Constipation
- Other: ______________________

I am interested in learning more about treatment alternatives to medications: Yes No