

### INCONTINENCE PATIENT PROFILE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer each question below by making a checkmark (✓) in the appropriate box.  
Bring this form with you to your first appointment.

1. How long have you had a problem with urinary leakage (incontinence)?
  - 1 week to 3 months
  - 3 to 12 months
  - 1 to 5 years
  - 5 to 10 years
  - More than 10 years
  - After surgery Type: \_\_\_\_\_
2. Did the urine leakage:
  - Began suddenly
  - Developed gradually over time
3. How often do you lose urine/water during a typical week?
  - Less than once a week
  - Once a week
  - More than once a week
  - Once a day
  - More than once a day
4. When does the leakage occur?
  - Mainly during the day
  - Mainly at night
  - Both day and night
5. When you leak/lose, how much do you leak?
  - Damp/a few drops
  - Wet enough to wet underpants
  - Quite wet, a cupful (soak pads/other protection)
6. When your bladder feels full, how long can you hold your urine?
  - Less than a minute or two
  - Just a few minutes
  - More than a few minutes
  - Cannot tell if bladder is full
7. Do you experience urinary leakage during any of the following?

<input type="checkbox"/> Coughing	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Rushing
<input type="checkbox"/> Laughing	<input type="checkbox"/> Running water
<input type="checkbox"/> Lifting heavy objects	<input type="checkbox"/> Cold weather
<input type="checkbox"/> Active exercise	<input type="checkbox"/> Continual leakage
<input type="checkbox"/> When changing position	<input type="checkbox"/> Dribbling after urination
<input type="checkbox"/> Walking	<input type="checkbox"/> While sleeping
<input type="checkbox"/> On the way to the bathroom	<input type="checkbox"/> Without being aware
<input type="checkbox"/> "Key in door" –when trying to open door	<input type="checkbox"/> Other _____
8. Do you have strong urinary urges you cannot always control?
  - Yes
  - No, never
9. Do you have trouble getting to the toilet on time?
  - Yes
  - No, never
10. How often do you urinate during the day?
  - More often than every hour
  - About every 1 to 2 hours
  - About every 3 to 5 hours
  - Frequency varies
  - Unknown
11. Do you wake up at night to urinate?
  - Never or rarely
  - About one to two times
  - Three or more times
12. When urinating, do you experience?
  - Problem starting stream
  - Weak, slow stream/dribbling
  - Pain
  - Discomfort
  - Burning
  - Blood in the urine

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13. Do you use any of the below for protection during urinary leakage? (Check all that apply)

- None
 Panty liner
 Sanitary napkins -feminine hygiene pads
 Minipads
 Guards for Men
 Undergarments (with straps or buttons)
 Protective Underwear - Disposable
 Adult briefs/diapers
 Bed or furniture pads
 Cloth garments
 Place pads in underwear
 Homemade pads, tissues,
 Bedside commode/urinal
 Other, please note below

14. How many times per day do you need to change pads or other products?

- 1  3  5
 2  4  6 or more

15. Have you ever seen an urologist or other doctor for your problem?

- Yes  No
Name (if, yes) \_\_\_\_\_
What did he/she do? \_\_\_\_\_

16. Are you avoiding certain activities because of a urine loss problem?

- Yes  No

17. Are you sexually active now?

- No  Yes, then answer a, b, c

a. Do you have difficulty getting or keeping an erection?

- Yes  No

b. If yes, did your problem start with prostate cancer surgery?

- Yes  No

c. Do you have pain/discomfort with intercourse?

- Yes  No

d. Do you ever leak/lose urine during intercourse?

- Yes  No

18. How often do you have a bowel movement?

- Once a day
 More than one per day
 2-3 times a week
 Less than 1 time once a week

19. Do you have any of the following?

- Constipation
 Diarrhea
 Bloody Stools
 None of the Above

20. Do you use laxatives?

- No  Yes, Which ones? \_\_\_\_\_

21. Do you ever lose control of your bowels?

- Yes  No

22. Has there been a change in the pattern of your bowel movements in the past year?

- Yes  No

23. Have you ever tried to do pelvic muscle exercises or Kegel exercises?

- No  Yes
If yes, describe how you have done them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_