GREATER BALTIMORE MEDICAL CENTER
DIVISION OF GYNECOLOGY/UROGYNECOLOGY

NAME_____ DOB _____

1. Please describe your current urinary problem and/or pelvic floor disorder: _____

   _____

2. Do you lose urine with coughing, sneezing, lifting, straining, aerobics, or exercise?

   Yes_____ No_____

3. Do you lose urine involuntarily wit urgency or without sensation before you can reach the toilet?

   Yes _____ No _____

How often, on average do you void during the day?:
(CIRCLE ONE)
Every: ½ hour 1 hour 1 ½ hours2 hours 2 ½ hours 3 hours >3 hours

4. How many times do you get up at night to urinate: (0, 1, 2, 3, 4, 5 times or more)

5. Do you wear protection because of urinary leakage? Yes_____ No_____

   If **YES**, circle one:
   Intermittent "Just in case" All waking hours Continuously

   Other_____

6. If you use pads for incontinence, what type of pads do you use? (please pick one)
   - None
   - Minipad
   - Shield
   - Diaper (Depends, etc…)

7. Do you have recurrent urinary tract infections? Yes_____ No_____
   If **YES** how often?
   (CIRCLE ONE)
   3/year 4/year 5/year More than 5/year

8. Do you experience any of the following with urination?

   pain discomfort severe urgency burning abdominal pain

   straining sensation of incomplete emptying blood in urine dribbling

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9. Have you had prior treatment for urinary incontinence? Yes_____ No_____
   If **YES**, circle each one that applies:

Behavioral-Pelvic Muscle Exercise Bladder Retraining Drills Biofeedback Electrical Stimulation

Drugs – Which ones? _____

Surgery – What Surgery? _____

10. Do you experience fullness or pressure in the vagina or bulging tissue at the vaginal opening?
    Yes _____ No_____

11. On average, how many bowel movements do you have per week? _____

12. Do you have problems with?;
    If **YES** please describe
    Diarrhea_____
    Constipation_____
    Fecal Incontinence _____

13. Are you sexually active? Yes_____ No_____
    If **YES**, do you experience?:
    Painful Intercourse _____
    Loss of interest in sex _____
    Vaginal dryness _____
    Vaginal bleeding with intercourse _____

14. Do you currently have any of the following medical problems:

Diabetes	Yes_____	No_____
Stroke	Yes _____	No _____
Other neurological problems	Yes _____	No _____

Please circle those that apply:

Parkinson's Multiple Sclerosis Spina Bifida

Paralysis Weakness

NAME_____ DOB _____

Greater Baltimore Medical Center
VOIDING DIARY/URO LOG

This chart is a record of your voiding (urinating) and leakage (incontinence) of urine. Please complete this according to the following instructions **PRIOR TO YOUR VISIT** to our office. Choose a **24-hour** period to keep this record when you can conveniently measure every voiding, and begin your record with the first voiding upon rising as in the sample below.

(1) TIME	(2) VOIDED	(3) LEAK VOLUME	(4) URGE PRESENT	(5)ACTIVITY	(6)AMOUNT/ TYPE INTAKE
6:45 am	550cc			Awakening	
7:00 am		2	Yes	Turned on water	2 cups coffee 6 oz orange juice

1. Record time of all voids, leakage, intake of liquids
2. Measure all intake and output in cc's or oz's
3. Estimate the amount of leakage according to the following scale:

   1 = Damp, few drops only

   2 = Wet underwear or pad

   3 = Soaked or emptied bladder
4. If the urge to urinate accompanied (or preceded) the urine leakage, write YES. If you felt no urge when the leakage occurred, write NO.
5. Describe activity you were performing at the time of the leakage. If you were not actively doing anything, record whether you were sitting, standing, or lying down.
6. Record the amount and type of all liquid intake using either cc's or oz's. (1 cup = 8oz = 240cc)

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VOIDING DIARY/URO LOG

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