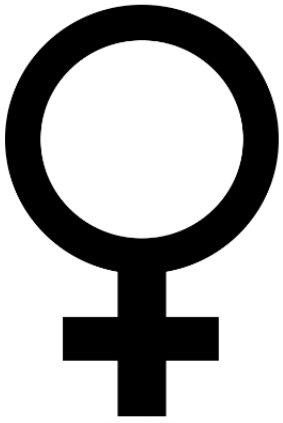

Female Patient

Paperwork for Urodynamics

CONSULTATION INFORMATION

UrologyAustin

www.urologyaustin.com

Rev May 2018

Patient Information Sheet and Instructions

IMPORTANT: Please call at least 24 hours in advance to cancel an appointment to prevent a cancellation fee.

General Questionnaire – The General Questionnaire should be filled out completely by all patients. You are correct that your chart and physician has the majority of the information, but the information is dispersed throughout the chart. Your answer to these questions and compilation allow the UD procedure nurse to have all the information in one place. Your help is crucial to the process. A nurse will review with you during your visit.

Medication Questionnaire – Fill out this questionnaire as thoroughly as possible. Attach a separate sheet or write on the back of the form if additional space is needed.

Bladder Diary – While the General Questionnaire is important**…**

the Bladder Diary is **crucial** to current and ongoing treatment options available to you.

The insurers (your insurance company) often request a copy of **your Bladder Diary** before they will approve any surgical recommendations made by your physician. The bladder diary is a 24-hour record of your intake, output and leakage episodes. It is important to record accurate data during the time period specified by your physician.

General Questionnaire: Female

DATE: _____

Patient Name: _____ **Date of Birth:** _____

Primary Reason for Visit: _____

Allergies: Latex Y N Iodine: Y N Other: _____

Other urologists you have seen: _____

Do you have chronic UTIs? Y N **How many per year?** _____

Have you ever tried Kegel Exercises or Bio-Feedback? Y N

Have you ever had physical therapy for your pelvic floor muscles? Y N

Ever had bladder instillations? Y N If yes, please describe: _____
(i.e. Medications infused into the bladder with a catheter?)

_____

Ever received diagnosis related to your urinary problems? Y N If yes, please describe:

_____

Indicate how often you experience the following:	**Never**	**Rarely**	**Sometimes**	**Often**
Do the following tasks cause you to lose urine:				
- Coughing gently?				
- Coughing hard?				
- Sneezing?				
- Lifting things?				
- Bending?				
- Laughing?				
- Walking briskly or jogging?				
- Straining, if constipated?				
- Changing positions from sitting to standing?				
- Washing your hands?				
- Cold weather?				
- Drinking cold beverages?				
- Seeing, hearing or feeling running water?				
Do you lose urine when you don't even know it?				
Some women receive very little warning and suddenly they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				

Female Questionnaire continued

How often do you urinate during your waking hours? _____

Do you wake up to urinate? Y N If yes, how many times per night? _____

Do you ever wake up wet? Y N If yes, how many times per week? _____

Are there any other activities, not previously listed, that make you lose urine? Y N

If yes, please list _____

Do you use protection for urinary leakage? Y N **If yes, how many per day?**

Toilet Paper _____ Tampons _____ Panty liners _____

Incontinence briefs _____ Shield-type pads _____

Please indicate the following:

Last menstrual period _____

Number of pregnancies: _____

Date(s) of any back surgeries: _____

Date of hysterectomy (if applicable): _____

Date(s) of any car accidents: _____

Date(s) of any spinal cord injuries: _____

Date(s) of any hemorrhoid surgeries: _____

Have you ever had a device implanted? Y N **If yes, please list:** _____
(i.e. Steel rods, IUD, Pacemaker, InterStim, other?)

Please list any injuries to the pelvic floor: _____

A nurse will call you prior to your visit to review questions

Medication Questionnaire

Date: _____

Patient Name: _____ Date of Birth: _____

Medication Allergies: _____

Significant Health Conditions: _____

Primary Care Physician: _____Phone Number: _____

Other Physician: _____Phone Number: _____

Please check the length of time you have tried any of the medications listed below. Please check if you are still taking or discontinued taking medications.

	1 mo.	2 mo.	4-6 mo.	6-12 mo.	12+ mo.	Still taking	Not working/ did not work	Med worked, quit due to side effects
Amitriptyline								
Detrol								
Ditropan								
Elmeron								
Enablex								
Flomax								
Oxytrol								
Sanctura								
Urecholine								
Uroxatral								
Vesicare								
Toviaz								
Rapaflo								
Myrbetriq								
Estrace Cream								
Premarin Cream								

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS
(YOU MAY ATTACH A LIST OR WRITE ON THE BACK IF NECESSARY)

Rx Start Date	Medication/ Supplement Name	Dose (mg)	How often?	Prescription? (Y/N)	Prescribing Physician (if applicable)	Rx Stop Date

Bladder Diary – Day #1

Name: _____

Date: _____

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output as well as leakage episodes. The "sample" line below will show you how to use the diary.

SPECIAL INSTRUCTION:
For patients who perform clean intermittent catheterizations, use "**C**" for amount catheterized out, and "**V**" for amount voided.

Time	Drinks		Urine			ACCIDENTS					
						Accidental Leaks How Much? (check one)			Did you feel a strong urge to go? Circle One		What were you doing at the time? (sneezing, having sex, lifting, etc.)
	What Kind?	How Much?	How many times did you pee during the hour?	How Much? C	How Much? V	Small	Medium	Large			
Sample	*Coffee*	*2 cups*	*2*	*2 oz.*	*2 oz.*	*X*			*Yes*	*No*	*Running*
6-7 am									Yes	No	
7-8 am									Yes	No	
8-9 am									Yes	No	
9-10 am									Yes	No	
10-11 am									Yes	No	
11-noon									Yes	No	
12-1 pm									Yes	No	
1-2 pm									Yes	No	
2-3 pm									Yes	No	
3-4 pm									Yes	No	
4-5 pm									Yes	No	
5-6 pm									Yes	No	
6-7 pm									Yes	No	
7-8 pm									Yes	No	
8-9 pm									Yes	No	
9-10 pm									Yes	No	
10-11 pm									Yes	No	
11-midnight									Yes	No	
12-1 am									Yes	No	
1-2 am									Yes	No	
2-3 am									Yes	No	
3-4 am									Yes	No	
4-5 am									Yes	No	
5-6 am									Yes	No	

Total Fluids In:

Day #1 _____

Total Urine Output:

Day #1 _____

Bladder Diary – Day #2

Name: _____

Date: _____

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output as well as leakage episodes. The "sample" line below will show you how to use the diary.

SPECIAL INSTRUCTION:
For patients who perform clean intermittent catheterizations, use "**C**" for amount catheterized out, and "**V**" for amount voided.

Time	Drinks		Urine			ACCIDENTS					
						Accidental Leaks How Much? (check one)			Did you feel a strong urge to go? Circle One		What were you doing at the time? (sneezing, having sex, lifting, etc.)
	What Kind?	How Much?	How many times did you pee during the hour?	How Much? C	How Much? V	Small	Medium	Large			
Sample	*Coffee*	*2 cups*	*2*	*2 oz.*	*2 oz.*	*X*			*(Yes)*	*No*	*Running*
6-7 am									Yes	No	
7-8 am									Yes	No	
8-9 am									Yes	No	
9-10 am									Yes	No	
10-11 am									Yes	No	
11-noon									Yes	No	
12-1 pm									Yes	No	
1-2 pm									Yes	No	
2-3 pm									Yes	No	
3-4 pm									Yes	No	
4-5 pm									Yes	No	
5-6 pm									Yes	No	
6-7 pm									Yes	No	
7-8 pm									Yes	No	
8-9 pm									Yes	No	
9-10 pm									Yes	No	
10-11 pm									Yes	No	
11-midnight									Yes	No	
12-1 am									Yes	No	
1-2 am									Yes	No	
2-3 am									Yes	No	
3-4 am									Yes	No	
4-5 am									Yes	No	
5-6 am									Yes	No	

Total Fluids In:

Day #2 _____

Total Urine Output:

Day #2 _____

Bladder Diary – Day #3

Name: _____

Date: _____

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output as well as leakage episodes. The "sample" line below will show you how to use the diary.

SPECIAL INSTRUCTION:
For patients who perform clean intermittent catheterizations, use "**C**" for amount catheterized out, and "**V**" for amount voided.

Time	Drinks		Urine			ACCIDENTS					
						Accidental Leaks How Much? (check one)			Did you feel a strong urge to go? Circle One		What were you doing at the time? (sneezing, having sex, lifting, etc.)
	What Kind?	How Much?	How many times did you pee during the hour?	How Much? C	How Much? V	Small	Medium	Large			
Sample	*Coffee*	*2 cups*	*2*	*2 oz.*	*2 oz.*	*X*			*(Yes)*	*No*	*Running*
6-7 am									Yes	No	
7-8 am									Yes	No	
8-9 am									Yes	No	
9-10 am									Yes	No	
10-11 am									Yes	No	
11-noon									Yes	No	
12-1 pm									Yes	No	
1-2 pm									Yes	No	
2-3 pm									Yes	No	
3-4 pm									Yes	No	
4-5 pm									Yes	No	
5-6 pm									Yes	No	
6-7 pm									Yes	No	
7-8 pm									Yes	No	
8-9 pm									Yes	No	
9-10 pm									Yes	No	
10-11 pm									Yes	No	
11-midnight									Yes	No	
12-1 am									Yes	No	
1-2 am									Yes	No	
2-3 am									Yes	No	
3-4 am									Yes	No	
4-5 am									Yes	No	
5-6 am									Yes	No	

Total Fluids In:

Day #3 _____

Total Urine Output:

Day #3 _____