Dr Simon Bariol

Urological Surgeon.

Urological History for Urodynamic Study.

This questionnaire will help Dr Bariol to assess your problem. Please be as accurate as you can. The information you give will be kept with your medical records & remain entirely confidential.

❖ **How long have you had a bladder problem?..... Months / years**

Tick the Type(s) of problems you have had.

- ☐ Recurrent Urinary Infection
- ☐ Blood in Urine
- ☐ Poor bladder control (Leakage)
- ☐ Difficulty Emptying Bladder
- ☐ Frequency / Urgency
- ☐ Getting up at Night
- ☐ Kidney Stones
- ☐ Pain
- ☐ Other .....

❖ **How frequently, on average, do you pass urine during the day?**

- ☐ Every 4 – 6 hours
- ☐ 3 – 4 hours
- ☐ 2 3 hours
- ☐ 1 – 2 hours
- ☐ Every hour
- ☐ More often

❖ **How often, on average, do you get up at night to pass urine?**

☐ Never ☐ Once ☐ Twice ☐ 3 4 Times ☐ 5 – 6 Times ☐ More

❖ **When you pass Urine, what is the flow like?**

☐ Good Stream ☐ Fair Stream ☐ Poor Stream ☐ Stops & Starts ☐ Varies a Lot

❖ **Delay in Starting:**

☐ Yes ☐ No

❖ **Dribbles Afterwards:**

☐ Yes ☐ No

❖ **Do you feel that your bladder empties completely when you pass urine?**

☐ Yes ☐ No ☐ Sometimes doesn't empty ☐ Don't Know ☐ Unsure

❖ **Do you have to go to the Lavatory urgently when you want to go?**

☐ Yes ☐ No

❖ **Why Is It Urgent?**

☐ Pain or Discomfort ☐ Fear of Leakage

❖ **Do you leak on the way to the toilet, if you can't get there in time?** ☐ Yes ☐ No

❖ **Do you ever leak when you cough or sneeze or lift something?** ☐ Yes ☐ No

❖ **Do you ever leak urine whilst sitting quietly in a chair?** ☐ Yes ☐ No

- **Do you ever leak urine during sexual intercourse?** ☐ Yes ☐ No
- **Do you leak in bed at night or wear a diaper at night?** ☐ Yes ☐ No
- **Did you wet the bed at night as a child?** ☐ Yes ☐ No

  Up To what Age?..... Years
- Do you get attacks of burning & stinging when you pass urine? ☐ Yes ☐ No
- Have you had Positive Urine Cultures for infection in such attacks? ☐ Yes ☐ No
- Have you had any obvious blood in urine? ☐ Yes ☐ No
- Any Bowel Problems? ☐ Yes ☐ No

  Specify:.....
- Have you had any previous surgery, as listed below, on your urinary tract?

☐ Marshall Marchettie	☐ Hysterectomy	☐ Vaginal Repair
☐ Cystoscopy	☐ Diathermy	☐ Colposuspension
☐ Prostate Operation	☐ Urethral Dilation	☐ Nerve Block Injection
☐ Stamey's Procedure	☐ Kidney Operation	☐ Sling Operation

- **Any Other Operations: State operation & approximate date surgery was performed?**

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- **Medication:** What medication(s) are you currently taking?

1.	Dose:.....	5.	Dose:.....
2.	Dose:.....	6.	Dose:.....
3.	Dose:.....	7.	Dose:.....
4.	Dose:.....	8.	Dose:.....

- **Allergies:.....**

Thank you for your co – operation.