Bladder Health Questionnaire

Please answer the questions about your individual health to help your doctor choose the right treatment for your bladder symptoms.

How bothered are you by the following incidents?

1.	Frequent urination during the daytime hours?	Not at all ☐	A little bit ☐	Somewhat ☐	A great deal ☐
2.	A sudden or uncontrollable urge to urinate with little or no warning?	Not at all ☐	A little bit ☐	Somewhat ☐	A great deal ☐
3.	Accidental loss of urine?	Not at all ☐	A little bit ☐	Somewhat ☐	A great deal ☐
4.	Urine loss due to a strong desire to urinate?	Not at all ☐	A little bit ☐	Somewhat ☐	A great deal ☐

Please answer the following questions.

5.	How many times are you getting up to void per night?	0 – 1 ☐	2-4 ☐	5 or more ☐

6. What Overactive Bladder (OAB) treatments have you tried (check all that apply)?

- ☐ Absorbent pads
- ☐ Behavioral modification (fluid management, dietary changes, bladder training)
- ☐ Biofeedback
- ☐ Pelvic muscle exercises (Kegel exercises)

7. Which OAB drugs have you taken and for approximately how long? (check all that apply & write length taken next to drug name)

☐ Enablex® _____ ☐ Flomax® _____ ☐ Detrol® _____ ☐ Ditropan® _____

☐ Santura® _____ ☐ Toviaz® _____ ☐ Vesicare® _____ ☐ Other _____

8. Have you experienced any intolerable side-effects from taking drugs to treat OAB (i.e., dry mouth, constipation, mental confusion, etc.)? Yes No

9. Which of these statements apply to you? (check all that apply)

- ☐ I have a pacemaker or implanted defibrillator
- ☐ I have nerve damage that could impact the tibial nerve or pelvic floor function
- ☐ I am pregnant or plan on becoming pregnant over the next 1-3 months
- ☐ I bleed excessively

10. Would you be interested in learning more about a non-surgical, non-drug treatment for your Overactive Bladder symptoms? Yes No