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CONTINENCE PROFILE

Name: _____ Chart #: _____ Date: _____

Describe your bladder problem in your own words.

<p>1. When did the problem first begin (month/year)? _____</p> <p>2. Do you lose urine with any of the following?</p> <p>A. Coughing, sneezing, laughing, lifting Yes No</p> <p>B. Active exercises (running, aerobics)? Yes No</p> <p>C. Minimal exercise (walking, housework)? Yes No</p> <p>D. Nervousness or increased anxiety? Yes No</p> <p>E. Leakage unrelated to a specific cause? Yes No</p> <p>F. Changing positions (sitting to standing)? Yes No</p> <p>3. Do you lose urine on the way to the bathroom? Yes No</p> <p>4. Prior to losing urine, do you have a feeling of urgency? Yes No</p> <p>5. Is urine loss by continuous dripping/dribbling, sudden spurts, sudden large spurts? Yes No</p>	<p>6. Do you wear protective perineal pads? Yes No Number per day and type: _____</p> <p>7. The majority of the time, how often do you urinate? (every ½ hour, 1 hour, 2 hours, 3 hours, etc) _____</p> <p>8. How many times do you awaken at night to urinate? _____</p> <p>9. Do you feel that you completely empty your bladder? Yes No</p> <p>10. Do you lose urine at night? (during sleep) Yes No</p> <p>11. Do you lose urine during sexual intercourse? Yes No</p> <p>12. After urination, does dribbling/dripping occur? Yes No</p> <p>13. Does the urine spray or hesitate? Yes No</p> <p>14. Does the urine stream start and stop before you finish urinating? Yes No</p> <p>15. Can you stop the stream of urine when urinating? Yes No</p>
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