**New Patient Questionnaire for Alexis Chesrow MD, FPMRS**

**What brings you in today?** _____

**What have you tried for this in the past?** _____

**How many times do you urinate during the day?** < 5 5-10 10-15 >15

**How many of these daytime urinations are URGENT?** < 25% 25% 50% 75% 100%

**Do you leak urine on the way to the washroom/comes out before you can sit down?** Yes No

Few drops Wet your underwear/pad Soak your clothes/pad

**How many times do you wake up from sleep to urinate?** 0-1 1-2 2-3 3-4 > 4

**Do you leak urine when you wake up to urinate?** Yes No

**Do you wake up from sleep already wet?** Yes No

**Do you leak urine with cough, sneeze, exercise or lifting (now or previously)?** Yes No

Few drops Wet your underwear/pad Soak your clothes/pad

**Number of pads/pullups/other used during the DAY for leakage?** _____

**Number of pads/pullups/other used WHILE ASLEEP for leakage?**_____

**Force of urinary stream?** Strong Weak Pause before it starts Starts and stops

**Do you feel like you empty your bladder all the way**? Yes No Sometimes

**Daily Fluids Consumption**: Water_____ Coffee_____ Tea_____ Juice_____ Soda_____

Other/Alcohol_____

**Do you feel a sense of prolapse (bulge or ball coming to the vaginal opening)?** Yes No

For how long? _____

Have you tried a pessary? _____

Any change in how you urinate or defecate? _____

Any need to push anything back into the vagina to urinate or defecate? Yes No

**Have you had any surgeries for incontinence or prolapse?** _____

**Previous Urological/Gynecological/Abdominal surgeries including hysterectomy?**

_____

**How many:** Vaginal Births _____ C- Sections _____ Largest Birth Weight _____

Any issues with the deliveries (rapid, prolonged, episiotomy)?_____

**Are you sexually active?** Yes No

**If no, would you like to be?** Yes No

**Any current or previous pain with intercourse?** Yes No

**Any Vaginal:** Pain Dryness Itching Skin Changes

**Any hormone replacement (vaginal or whole body)?**_____

**How often do you typically have a bowel movement?** _____/Day _____/Week _____/Month

**Is your stool:** Loose Soft Formed Hard

**Any fecal urgency or fecal incontinence episodes?** _____/Day _____/Week _____/Month

**Any neurological issues?** CVA/TIA/Stroke/Head Injury Back Surgery/Spinal Issues

Memory Issues/Dementia Parkinson's Multiple Sclerosis Anxiety/Depression/Bipolar

_____

**Ever see or been told you have blood in the urine?** Yes No

**Any previous renal stones?** Yes No

Passed on their own ESWL(Shock-Wave) Ureteroscopy Ureteral Stent PCNL

**Any issues with urinary tract infections/Bladder infections?** Yes No

How many in the last 12 months: _____

**Any pediatric issues with:** urination incontinence constipation UTI

**Are you diabetic?** Yes No **Last HGA1C value?**_____

**Any history of or current:** cancer radiation steroid use blood thinners

**Current or previous smoker**? Yes No For how many years? ____ Max number packs/day? ____

**Any significant chemical exposure?** _____

**Any other major health issues?** _____