Patient Name: _____ Date of Birth: _____

The following information will be used to help your provider understand your history and better plan for your treatment. Please circle all that apply. Please be detailed and complete in your answers.

Retention - Unable to urinate	Yes	No	❑ Less than 6 months ❑ 6 months to 1 year ❑ Greater than 1 year
Do you self-catheterize?	Yes	No	If yes, how many times per day? _____
Urgency/Frequency - Have to go right away/often	Yes	No	❑ Less than 6 months ❑ 6 months to 1 year ❑ Greater than 1 year
How many times do you urinate during the day?	1-4 times	5-9 times	10-20 times 20-30 times
How many times do you urinate during the night?	0 times	1-2 times	3-4 times 5 or more times
Urge Incontinence - Urinary Leakage	Yes	No	❑ Less than 6 months ❑ 6 months to 1 year ❑ Greater than 1 year
If you use pads for protection, how many pads are used in a 24 hour period?	**Quantity:** _____ 1-3 pads _____ 3-5 pads _____ 5+ pads **Pads are used for:** _____Urine _____ Feces (Stool) _____Both urine & feces		
Have you tried and failed any of the options here (check all that apply):	❑ Kegels ❑ Pelvic Floor Exercises ❑ Biofeedback ❑ Absorbent pads ❑ Diet Modification (Limiting bladder irritants, caffeine, etc.) ❑ Fluid Management (Limiting fluids before bedtime/during day) ❑ Behavioral Therapy ❑ Timed Voiding/Planned Voiding		
Fecal Incontinence – Leakage of feces/inability to control bowel movements	Average number of episodes per week: _____ Length of symptoms (in years): _____ Have you been diagnosed with inflammatory Bowel Disease, anorectal malformation, or a neurological condition for your fecal incontinence? **YES NO** Anal or rectal surgery in the past 12 months? **YES NO Surgery: _____** **Females:** Symptoms persisted more than 12 months after vaginal delivery? **YES NO**		
How do your symptoms negatively affect your quality of life?	❑ Pain/Discomfort ❑ Affects my job ❑ Affects my self esteem ❑ Affects normal movement (activities of daily living such as bending over) ❑ Interferes with exercise/activities important to me ❑ Other		

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Medications Trialed and Responses: If yes, place and "X" in appropriate box for response			**How many month(s) did you trial/take medication?**	**Did not help with symptoms at all**	**Helped at first, but then stopped**	**Helped, but could not tolerate the side effects**	**Helped and relieved ALL symptoms**
Enablex (Darifenacin)	Yes	No	___ months				
Ditropan (Oxybutynin)	Yes	No	___ months				
Vesicare (Solifenacin)	Yes	No	___ months				
Sanctura (Trospium)	Yes	No	___ months				
Oxytrol (Oxybutynin)	Yes	No	___ months				
Toviaz (Fesoterodine)	Yes	No	___ months				
Detrol (Tolterodine)	Yes	No	___ months				
Flomax (Tamsulosin)	Yes	No	___ months				
Myrbetriq (Mirabegron)	Yes	No	___ months				
Medications for Fecal Incontinence: - Loperamide - Lomotil - Cholestyramine - Tricyclic **Antidepressants:** - Fiber Supplements - Opiates - Other _____	Yes	No	___ months				
Other(s) _____	Yes	No	___ months				

Patient Signature: _____ Date: _____