Vikas Merchia, MD, FACOG
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830 Oak St, Suite 102w, Brockton, MA 02301
Tel 508.521.9259 – Fax 508.897.4778 – info@urogynob.com – www.urogynob.com

Urodynamic Testing Information Date: _____ Time: _____

Please come with a relatively FULL BLADDER. DO NOT urinate or drink a lot just before your appointment!

Cancelling less than 24 hours before the appointment, may result in a charge for a missed appointment.
If you don't speak English, it is your responsibility to bring someone who does and can translate for you!

What is an urodynamic study?
An urodynamic study is a test that is used to study the function of your bladder and urethra (the tube from the bladder to the outside of the body). The test is very important as we can learn information that may influence treatment for conditions including incontinence, voiding problems, and pelvic/bladder pain.

How is the study done?
When you arrive, we will place a tiny catheter (tube) into the bladder in order to fill the bladder with water. A second catheter is inserted in the rectum (or vagina) to measure pressures from the abdomen. The catheters are connected to a machine that records many important pieces of information regarding your bladder during filling and emptying.

How long is the study?
We have set aside 30 minutes for your test. The test usually takes 15-20 minutes. If you are unable to keep your appointment, please call the office and reschedule as soon as possible, preferably 48 hours or earlier to avoid penalty.

How do I prepare?
Please come with a FULL BLADDER for your appointment! There is no advance preparation or medication required for the test. If you are on certain "bladder" medications, you may be asked to stop them for one to two weeks prior to the exam. If you have a light period, it is still OK to have the test performed. You may drive after the test.

What do I do during the study?
During the study you will be asked to let us know when you have the following sensations as your bladder is filled:
First sensation that you feel something in the bladder, may consider urination, but don't have to.
First desire that you need to urinate but can hold it for 30 minutes.
Strong desire that you need to urinate but can hold it for 5 minutes.
Capacity that you need to urinate now, and can't hold it any longer.
You will be in a seated or standing position, and should be very still during the study. You will be asked to cough and bear down periodically during the test to check for urinary leakage and evaluate bladder and urethral pressures.

Does it hurt?
You may experience some bladder irritation (burning, stinging, pressure, or urinary frequency). Please drink plenty of water after this test. These symptoms resolve within 12 hours. Please call the office, 508-521-9259, for any symptoms lasting more than 24 hours. If the urine test (UA C&S) is suspicious for an infection, please give us your pharmacy's phone number: _____ and your phone number _____ or email address _____ where we may contact you or leave a message.
Final urine culture result usually takes 48 – 72 hours to complete.

What happens following the testing?
We will interpret the test upon completion and will discuss the test results as well as further management / treatment options with you on a follow-up visit. This follow up appointment will be scheduled for you at the end of testing.

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Pelvic Floor Prolapse & Urodynamic Testing Questionnaire

Why are you here today?❑ Urinary Incontinence, ❑ Urinary Retention, ❑ Prolapse, ❑ Referred by Doctor, ❑ Other _____
What do you hope to achieve / What is the goal of treatment?

Do you ever have problems holding your urine? ..... ❑ Yes / ❑ No
Do you ever have to strain or reduce a bulge to urinate? ..... ❑ Yes / ❑ No
Do you ever have urinary hesitancy or a slow, weak urine stream? ..... ❑ Yes / ❑ No
After urinating, do you ever have the feeling that you didn't fully empty your bladder? ..... ❑ Yes / ❑ No
How long have you had these symptoms? ..... _____ Years .... _____ Months..... _____ Weeks
Are your symptoms? ..... ❑ getting better ... ❑ staying the same .❑ getting worse

Have you had any kidney? ❑ infections ❑ stones ❑ flank pain ❑ pubic pain ❑ groin pain ❑ mass

Do any of the following urinary problems bother you?: ❑ no problems

❑ difficult urination	❑ painful urination	❑ burning with urination	❑ burning after urination
❑ cloudy urine	❑ spraying or split stream	❑ stream starts and stops	❑ takes a long time to empty
❑ foul smelling urine	❑ air in urine	❑ stool in urine	❑ urinate twice or more to empty
❑ dribbling after urinating	❑ urinary retention	❑ visible blood	❑ microscopic blood

Do you have **urinary frequency** (having to go to bathroom more than what you think is "normal")? ..... ❑ Yes / ❑ No
How many times do you go to the bathroom during the day (circle one)? ..... 1-3.....4-8 ..... 9-12..... More than 12
How often do you get up at night to go to the bathroom **(nocturia)**? (circle one) ..... None ..... 1 .....2-3 ..... 4 or more
Have you every wet your bed at night while sleeping **(enuresis)**? ..... ❑ Yes / ❑ No

How many times in a day do you leak urine (circle one)? ..... 0.... 1.....2.....3 ....4 ....5 .... 6 .... 7.... 8.....9.....10 ..... more
Do you have **urinary urgency** (when you have the desire to go, you can't wait or hold it) and leak urine? ..... ❑ Yes / ❑ No

❑ on way to toilet	❑ putting key in door	❑ cold weather	❑ without realizing it	❑ quiet continuous leakage
❑ while sleeping	❑ when getting out of car	❑ running water	❑ urethral discharge	❑ history of bladder cancer

Do you leak urine with activity **(genuine stress urinary incontinence)** check all that apply: ..... ❑ Yes / ❑ No

❑ coughing	❑ sneezing	❑ laughing	❑ lifting	❑ sitting	❑ walking	❑ running
❑ standing	❑ bending	❑ orgasm	❑ intercourse	❑ sports	❑ climbing stairs	❑ shouting/yelling

Do you need to use or **change pads / underwear / other incontinence products**? ..... ❑ Yes / ❑ No
If so how often do you change them? (circle one)..... 0.... 1.....2.....3 ....4 ....5 .... 6 .... 7.... 8.....9.....10 ..... more
What other things cause you to leak urine?

Are you sexually active?..... ❑ Yes / ❑ No
If so, do you ever experience any pain or discomfort with:.... ❑ sex ..... ❑ entry into vagina .. ❑ deep penetration into vagina

How many bladder infections have you had in the past 12 months? .... 0.... 1.....2.....3 ....4 ....5 .... 6 .... 7.... 8.....9.....10 ..more

How many times have you been pregnant? ____ How many vaginal births? ___ How much did your largest child weigh? _____
Did you have any incontinence issues: ❑ before pregnancy ❑ during your pregnancy ❑ after your delivery

Have you had a hysterectomy? ❑ No ❑ Vaginal ❑ Abdominal .. When? _____.....Why? _____
Do you still have your ovaries? ❑ Yes / ❑ No ..... Are you menopausal? ❑ Yes / ❑ No
Have you experienced any spotting or bleeding since menopause? ..... ❑ Yes / ❑ No
Have you ever been on hormone / estrogen replacement therapy? ..... ❑ Yes / ❑ No

Have you had previous surgery for incontinence? ❑ Yes / ❑ No Did your symptoms improve after surgery? ❑ Yes / ❑ No
What surgery did you have, and when did you have it? .....

Are you presently taking any medications for urinary symptoms? ❑ Yes / ❑ No, What? _____For how long? _____
Have it helped your symptoms? ❑ Yes / ❑ No, How? _____ What can be improved? _____

What medications have you tried; and for how long: ❑ Detrol_____, ❑ Ditropan_____, ❑ Enablex_____, ❑ Vesicare_____, ❑ Oxytrol_____, ❑ Sanctura_____, ❑ Myrbetriq_____

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Pelvic Floor Distress Inventory PFDI SF-20 (POPDI-6, CRADI-8, UDI-6)

Directions: Listed below are a series of questions regarding your bowel, bladder or pelvic symptoms as well as your degree of discomfort, if any. Please place a check next in the appropriate column for each question below. *While answering these questions, please consider your symptoms over the last 3 months.*	0 = No	1 Not At All	2 Somewhat	3 Moderately	4 Quite A Bit
Pelvic Organ Prolapse Distress Inventory (POPDI-6)					
1. Do you experience pressure in the lower abdomen?					
2. Do you experience heaviness or dullness in the pelvic area?					
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?					
4. Do you have to push on the vagina or rectum to complete a bowel movement?					
5. Do you experience a feeling of incomplete bladder emptying?					
6. Do you have to push up on a bulge in the vaginal area to start/complete urination?					
Colorectal-Anal Distress Inventory 8 (CRADI-8)					
1. Do you feel you need to strain too hard to have a bowel movement?					
2. At the end of a bowel movement, do you feel you have not completely emptied your bowels?					
3. If your stool is well formed, do you lose stool beyond your control?					
4. If your stool is loose or liquid, do you lose stool beyond your control?					
5. Do you lose gas from the rectum beyond your control?					
6. Do you have pain when you pass your stool?					
7. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?					
8. Does a part of your bowel ever pass through your rectum and bulge outside, during, or after a bowel movement?					
Urinary Distress Inventory 6 (UDI-6)					
1. Do you usually experience frequent urination?					
2. Do you experience urine leakage associated with a strong sensation of needing to go to the bathroom?					
3. Do you experience urine leakage related to coughing, sneezing, or laughing?					
4. Do you experience small amounts of urine leakage (that is drops)?					
5. Do you experience difficulty emptying your bladder?					
6. Do you experience pain or discomfort in the lower abdomen or genital region?					

Scale scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.
PFDI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).
The scales are scored from 0 (least impact) to 100 (greatest impact) and an overall summary score (0 to 300)

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Pelvic Floor Impact Questionnaire (PFIQ SF-7)

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. Place an X in the response that best describes how much: your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms over the past 3 months.

	Bladder or urine **UIQ**				Bowel or rectum **CRAIQ**				Vagina or Pelvis **POPIQ**			
UIQ = Urinary Impact Questionnaire **POPIQ** = Pelvic Organ Prolapse Impact Questionnaire **CRAIQ** = ColoRectal-Anal Impact Questionnaire **How do symptoms or conditions related to the following usually affect your:**	0=Not at all	1=Somewhat	2=Moderately	3=Quite a bit	0=Not at all	1=Somewhat	2=Moderately	3=Quite a bit	0=Not at all	1=Somewhat	2=Moderately	3=Quite a bit
1. Ability to do household chores (cooking, housecleaning, laundry)?												
2. Ability to do physical activities such as walking, swimming, or other exercise?												
3. Entertainment activities such as going to a movie or concert?												
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?												
5. Participating in social activities outside your home?												
6. Emotional Health (nervousness, depression, etc.)?												
7. Feelings of frustration?												
Total												

The PFIQ-7 consists of 3 scales of 7 questions each taken from:
Urinary Impact Questionnaire (UIQ-7): 7 items under column heading “Bladder or urine”
Colorectal-Anal Impact questionnaire (CRAIQ-7): 7 items under column heading “Bowel / rectum”
Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): Items under column “Pelvis / Vagina”

Scoring: Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Scale Scores: Obtain the mean value for all of the answered items within the corresponding scale (possible value 0 – 3) and then multiply by (100/3) to obtain the scale score (range 0-100). Missing items are dealt with by using the mean from answered items only.

PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0-300). **The 3 scales are scored from 0 (least impact) to 100 (greatest impact) and an overall summary score (0 to 300)**

Items 1 and 2 = physical activity; Items 3 and 4 = travel; Item 5 = social/relationships; Items 6 and 7 = emotional health

Reference: Uebersax, J.S., Wyman, J. F., Shumaker, S. A., McClish, D. K., Fantl, J. A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: The incontinence impact questionnaire and the urogenital distress inventory. Neurourology and Urodynamics, 14, 131-139.

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Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Are you currently sexually active?

- ❑ No, I am not able (Thank you, you are done with the questionnaire, go to next page)
- ❑ No, I have too much pain (Thank you, you are done with the questionnaire, go to next page)
- ❑ No, I have no desire (Thank you, you are done with the questionnaire, go to next page)
- ❑ No, I do not have a partner (Thank you, you are done with the questionnaire, go to next page)
- ❑ No, my partner is not able (Thank you, you are done with the questionnaire, go to next page)
- ❑ Yes, proceed with next 12 questions (PISQ-12)

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help the doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the question, consider your sexuality over the past six months. Thank you for your help.

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.
   ❑ Never (0) ❑ Less than Once a Month(1) ❑ Monthly (2) ❑ Weekly (3) ❑ Daily (4)

	Never (0)	Seldom (1)	Sometimes(2)	Usually (3)	Always (4)
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?					
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?					
4. How satisfied are you with the variety of sexual activity in your current sex life?					
5. Do you feel pain during sexual intercourse?					
6. Are you incontinent of urine (leak urine) with sexual activity?					
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?					
8. Do you avoid sexual intercourse because of bulging in the pelvis with the bladder, rectum or vagina falling out?					
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?					
10. Does your partner have a problem with erections that affect your sexual activity?					
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?					

12. Compare to orgasms you have had in the past, how intense are the orgasms you have had in the past six months? ❑ Much more (0) ❑ More (1) ❑ Same (2) ❑ Less (3) ❑ Much less (4)

PISQ-12 has a range from 0 to 48 with higher scores indicating better sexual function.

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The Pelvic Pain and Urinary/Frequency (PUF)

Patient Symptom Scale	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3–6	7–10	11–14	15–19	20+	s	
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+	s	
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			b
3. Are you currently sexually active? Yes No							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always		s	
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			b
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always		s	
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always		s	
7a. If you have pain, is it usually...		Mild	Moderate	Severe		s	
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			b
8a. If you have urgency, is it usually...		Mild	Moderate	Severe		s	
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			b
Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a)						s	
Bother Score (2b, 4b, 7b, 8b)							b
Total Score (Symptom Score + Bother Score)							

Total Score	Likelihood of positive PST
10-14	74%
15-19	76%
20 or above	91%

Total score ranges from 1 to 35.

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Interstitial Cystitis (IC) Symptom and Problem Questionnaire

Assessing IC – To help your physician determine if you have IC, please put a check mark next to the most appropriate response to each of the questions shown below. Then add up the numbers to the left of the check marks and write the total below.

Interstitial Cystitis – Symptom Index *During the past month:*	**Interstitial Cystitis – Problem Index** *During the past month, how much has each of the following been a problem for you:*
Q1. How often have you felt the strong need to urinate with little or no warning? 0. __ Not at all 1. __ Less than 1 time in 5 2. __ Less than half the time 3. __ About half the time 4. __ More than half the time 5. __ Almost always	Q1.Frequent urination during the day? 0. __ No problem 1. __ Very small problem 2. __ Small problem 3. __ Medium problem 4. __ Big problem
Q2. Have you had to urinate less than 2 hours after you finished urinating? 0. __ Not at all 1. __ Less than 1 time in 5 2. __ Less than half the time 3. __ About half the time 4. __ More than half the time 5. __ Almost always	Q2. Getting up at night to urinate? 0. __ No problem 1. __ Very small problem 2. __ Small problem 3. __ Medium problem 4. __ Big problem
Q3. How often did you most typically get up at night to urinate? 0. __ None 1. __ Once 2. __ 2 times 3. __ 3 times 4. __ 4 times 5. __ 5 or more times	Q3. Need to urinate with little warning? 0. __ No problem 1. __ Very small problem 2. __ Small problem 3. __ Medium problem 4. __ Big problem
Q4. Have you experienced pain or burning in your bladder? 0. __ Not at all 1. __ A few times 2. __ Almost always 3. __ Fairly often 4. __ Usually	Q4. Burning, pain, discomfort, or pressure in your bladder? 0. __ No problem 1. __ Very small problem 2. __ Small problem 3. __ Medium problem 4. __ Big problem
Symptom Index (sum of checked entries): ____/19	**Problem Index (sum of checked entries): ____/16**
Sum of Symptom and Problem Indices: _____/35	**If Total Score > 6 IC possible; > 12 strong evidence**

Adapted with permission from O'Leary MP, Sant GR, Fowler FJ Jr, Whitmore KE, Spolarich-Kroll J. The interstitial cystitis symptom index and problem index. Urology. *1997;49(5A suppl):62*

O'Leary-Sant Symptom and Problem Index. A total score (symptom + problem index) greater than 6 suggests that interstitial cystitis/painful bladder syndrome is possible, and a score greater than 12 is strong evidence in favor of the diagnosis.

Bladder Symptom Questionnaire

Name: Date:

Doctor:

Which symptoms best describe you? Select all that apply.

Frequent urination—day, night, or both
Sudden or strong urge to urinate
Leakage with little or no warning—sometimes unable to make it to the bathroom in time
Unable to completely empty bladder—feels like there is more even after going to the bathroom
Accidental leakage with physical activity—exercising, sneezing, or coughing
Bladder or pelvic pain
Problems with bowel function (if checked, please select symptom below)
Accidental loss or leakage of stool Constipation Other
No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried?

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? Yes No

if no, why have you stopped taking them?

Did not work as well as expected Side effects Expense
Interaction with other medications Other

If Side effects or Other checked, please explain:

Behavior modifications tried?

(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physicial therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Select a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

Yes No

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VOIDING DIARY INSTRUCTIONS: **Date: _____**

1. Begin recording upon rising in the morning–continue for a full 24 hours. Complete for at least 3-4 days
2. Pick days which are representative of your lifestyle when you notice your symptoms and record the following.
3. Record each day on a separate page. Please bring this diary with you to your next visit.
4. Record each event (drinking, urination/voiding, urge, and leaking) on separate lines at the time they occur.
   a. Fluid intake - write down the time you drink anything, approximately how much in ounces, and what you drank.
   b. Urination - Output/Voids - write down the time you urinate, the quality of output
   c. Leaking - with each leak please indicate the time, volume and your activity during the leak.
   d. Urge - record strong desire to urinate, with or without urinary leakage (y=yes / n=no)

	TIME	Fluid intake / drink	Urination	Urge	Leaking	Activity during leaking
		- approximate amount in ml/oz - what you drank (water, coffee, coke, tea, etc.)	Output/voids 1 = dribble 2 = stream 3 = bladder emptied	(y/n)	Leak Volume 1 = drops/damp 2 = wet 3 = soaked	e.g. sneeze, standing, sitting, coughing, laughing, running, etc.
	7:00 am	Example	*3*	*y*		Urination with urge no leaking
	7:30 am	*8 oz / Herbal tea*				Drinking fluid
	8:30 am			*y*		Urge no leaking
	8:45 am			*y*	*1*	Urge with Leak
	9:00 am				*1*	Sneeze - Leaking with activity
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
	Totals					

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   c. Leaking - with each leak please indicate the time, volume and your activity during the leak.
   d. Urge - record strong desire to urinate, with or without urinary leakage (y=yes / n=no)

	TIME	Fluid intake / drink	Urination	Urge	Leaking	Activity during leaking
		- approximate amount in ml/oz - what you drank (water, coffee, coke, tea, etc.)	Output/voids 1 = dribble 2 = stream 3 = bladder emptied	(y/n)	Leak Volume 1 = drops/damp 2 = wet 3 = soaked	e.g. sneeze, standing, sitting, coughing, laughing, running, etc.
	7:00 am	Example	*3*	*y*		Urination with urge no leaking
	7:30 am	*8 oz / Herbal tea*				Drinking fluid
	8:30 am			*y*		Urge no leaking
	8:45 am			*y*	*1*	Urge with Leak
	9:00 am				*1*	Sneeze - Leaking with activity
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
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22						
23						
24						
25						
26						
	Totals					

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830 Oak St, Suite 102w, Brockton, MA 02301
Tel 508.521.9259 – Fax 508.897.4778 – info@urogynob.com – www.urogynob.com

VOIDING DIARY INSTRUCTIONS: **Date: _____**

1. Begin recording upon rising in the morning–continue for a full 24 hours. Complete for at least 3-4 days
2. Pick days which are representative of your lifestyle when you notice your symptoms and record the following.
3. Record each day on a separate page. Please bring this diary with you to your next visit.
4. Record each event (drinking, urination/voiding, urge, and leaking) on separate lines at the time they occur.
   a. Fluid intake - write down the time you drink anything, approximately how much in ounces, and what you drank.
   b. Urination - Output/Voids - write down the time you urinate, the quality of output
   c. Leaking - with each leak please indicate the time, volume and your activity during the leak.
   d. Urge - record strong desire to urinate, with or without urinary leakage (y=yes / n=no)

	TIME	**Fluid intake / drink**	**Urination**	**Urge**	**Leaking**	**Activity during leaking**
		- approximate amount in ml/oz - what you drank (water, coffee, coke, tea, etc.)	Output/voids 1 = dribble 2 = stream 3 = bladder emptied	(y/n)	Leak Volume 1 = drops/damp 2 = wet 3 = soaked	e.g. sneeze, standing, sitting, coughing, laughing, running, etc.
	7:00 am	Example	*3*	*y*		Urination with urge no leaking
	7:30 am	*8 oz / Herbal tea*				Drinking fluid
	8:30 am			*y*		Urge no leaking
	8:45 am			*y*	*1*	Urge with Leak
	9:00 am				*1*	Sneeze - Leaking with activity
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
	Totals					

Vikas Merchia, MD, FACOG
Board Certified in Female Pelvic Medicine and Reconstructive Surgery (Urogynecology)
Board Certified in Obstetrics and Gynecology
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	8:30 am			*y*		Urge no leaking
	8:45 am			*y*	*1*	Urge with Leak
	9:00 am				*1*	Sneeze - Leaking with activity
1						
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3						
4						
5						
6						
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8						
9						
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11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
	Totals					

Medtronic

Bladder Symptom Tracker

Patient Name _____

Date _____

Track your symptoms in the chart below for as many days as your doctor recommends. Record one episode per row.
If you had no episode on a given day, record that as well. Please record your urgency rating even if you did not experience leakage.

DAY _____	OAB				Retention	
Time	Void ✓	Leak ✓	Change Pad Y or N	Urgency? Rate 1–5 (5 is high)	Voided Volume	Cathed Volume (or PVR)
8:15 (AM) PM	✓	✓	Y	5		
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
TOTALS						

Since starting the evaluation, how do you perceive your symptoms when compared to before the treatment?

Much worse 1 2 3 *Same* 4 5 6 7 *Much better*

DAY _____	OAB				Retention	
Time	Void ✓	Leak ✓	Change Pad Y or N	Urgency? Rate 1–5 (5 is high)	Voided Volume	Cathed Volume (or PVR)
8:15 (AM) PM	✓	✓	Y	5		
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
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AM PM						
AM PM						
AM PM						
AM PM						
AM PM						
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AM PM						
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CONSTIPATION / BOWEL HEALTH

1. Do you have any uncontrolled leakage of (circle all that apply) gas, liquid, solid stool or none?
2. On a scale of 0 to 100, where zero represents death and 100 represents perfect health; please indicate how you would rate your current state of health. ___ ___ ___ (1 – 100)

Please write down if you have any of the following symptoms and mark how much of these affect you.

	Not applicable	None	A little	Moderately	A lot
Bowels do not feel completely empty after opening					
Constipation; difficulty in emptying					
Straining to open your bowels					
Vaginal bulge which gets in the way of sex					
Lower backache worsens with vaginal discomfort					
Do you help empty your bowels with your fingers					
	More than once a day	Once a day	Once every 2 days	Once every 3 days	Once a week or more
How often do you open your bowels					

Wexner Constipation Questionnaire (circle answer)

1. Evacuation frequency a. 1-2 times per day b. 2 times per week c. 1 time per week d. <1 time per week e. <1 time per month	**4. Duration of constipation (in years)** a. 0 b. 1-5 c. 5-10 d. 10-20 e. >20
2. Time necessary to evacuate (in minutes) a. <5 b. 5-10 c. 10-20 d. 20-30 e. >30	**5. Incomplete evacuation** a. Never b. Rarely c. Sometimes d. Usually e. Always
3. Difficulties in evacuation a. Never b. Rarely c. Sometimes d. Usually e. Always	**6. Abdominal pain** a. Never b. Rarely c. Sometimes d. Usually e. Always

Fecal Incontinence Severity Index (FISI)

For each of the following, please indicate on average how often in the past month you experience any amount of accidental bowel leakage (Check only one box per row)

Type of Fecal Incontinence	Never	Once a week	1 to 3 times per month	2 or more times a week	Once a day	2 or more times a day
Gas						
Mucus						
Liquid Stool						
Solid Stool						

Bowel Symptom Questionnaire

Name: Date:

Doctor:

Which symptoms best describe you? Select all that apply.

- Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time
- Bowel accidents while unaware—no warning and/or while asleep
- Frequent, loose, watery stools
- Sudden or strong urge to go to the bathroom
- Bowel accidents when passing gas
- No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Approximately how many bowel incidents do you have per week?

Have you tried medications to help your symptoms? Yes No

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Behavior modifications tried?

(e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bowel medications?

Yes No

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Patient Name _____

Date _____

Bowel Symptom Tracker

Track your symptoms in the chart below for as many days as your doctor recommends. Record one bowel episode per row.
If you had no episodes on a given day, record that as well. Please record your urgency rating even if you did not experience leakage.

DAY _____

Time	Urgency Rating 1-5 (5 being most urgent)	# of Pads	Stool Description*	Did You Have an Accident? Yes/No	If Yes, Amount of Soil: **S**light/**M**oderate/**H**eavy
9:00 (AM) PM	5	2	4	Yes	H
AM PM					
AM PM					
AM PM					
AM PM					
AM PM					
AM PM					
AM PM					
AM PM					
AM PM					
AM PM					
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AM PM					
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AM PM					
AM PM					
AM PM					
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AM PM					
AM PM					
AM PM					
AM PM					
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AM PM					
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AM PM					
AM PM					
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*Stool Description

Use these numbered drawings to indicate in the diary what type of event occurred.

1 pellets

2 formed and hard

3 formed and soft

4 semi-formed

5 mushy

6 loose

7 watery

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