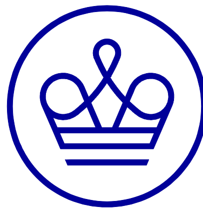


Rhineland Pelvic Floor Centre
Düsseldorf

DR. MED. KOUROSH TAGHAVI
Luise-Rainer-Straße 6-10
40235 Düsseldorf Germany

Ms

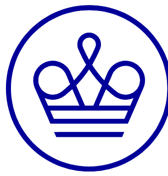
Date:

Questionnaire from:

Surname, first name:
Date of birth:
Address:
Telephone number:
Weight in kg:
Number of vaginal births:
Number of caesareans:
Please describe the duration of your symptoms and the main reasons why you are attending our urogynaecological clinic.

Please take some time to answer a few questions.

Stress incontinence symptoms	**No**	**Yes,** sometimes	**Often** (50% of the time or more)
Do you lose urine when:			
- Sneezing	☐	☐	☐
- Coughing	☐	☐	☐
- Exerting yourself physically	☐	☐	☐
(1) Walking	☐	☐	☐
(2) Bending down, crouching, standing up from a chair	☐	☐	☐



Bladder emptying symptoms	**No**	**Yes,** sometimes	**Often** (50% of the time or more)
Do you produce a continuous stream of urine?	☐	☐	☐
Do you have the feeling that your bladder is not completely emptying?	☐	☐	☐
Have you ever had difficulties in starting to pass water?	☐	☐	☐
Do you have a slow urine flow?	☐	☐	☐
Urge incontinence symptoms	**No**	**Yes,** sometimes	**Often** (50% of the time or more)
Have you ever had an uncontrollable, sudden urge to urinate?	☐	☐	☐
If yes, have you ever passed any urine before reaching the toilet?	☐	☐	☐
If yes, how many times does this happen each day? - On a "good day" - On a "bad day"		**Number of times**	

How much urine do you lose when this happens?	**Yes**	**No**
- A few drops	☐	☐
- A teaspoon	☐	☐
- A tablespoon	☐	☐
Do you ever feel any pain when urinating?	☐	☐

	Number of times
How many times do you have to get up in the night to urinate?	
How many times do you go to the toilet to urinate during the day?	

	No	**Yes,** sometimes	**Often** (50% of the time or more)
Do you have to urinate as soon as you get up in the morning?	☐	☐	☐

	Yes	**No**
Did you wet the bed as a child, but stop doing so on reaching puberty?	☐	☐
Did your problems start shortly after puberty?	☐	☐
Do your symptoms increase shortly before your period starts?	☐	☐

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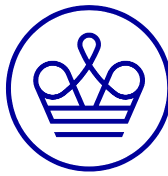

Intestinal problems	Yes	No
Do you have any difficulty emptying your bowels? Have you ever soiled yourself? - When passing wind - With a loose stool - With a solid stool	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

Impact on your everyday life	Yes	No
Do you ever notice that you smell of urine? Do you ever pass urine at night when in bed?	☐ ☐	☐ ☐

	No	Now and again	Always
Do you use incontinence pads when leaving the house?	☐	☐	☐

	Number of pads
If yes, how many pads do you use a day?	

Previous operations	Yes	No
Have you had a hysterectomy? If yes, please state the date of the operation.	☐	☐
Have you ever had any operations as a result of your incontinence problems? If yes, please state the date of the operation.	☐	☐
Have you ever had any operations in your vaginal area? If yes, please state the date of the operation.	☐	☐
	Improved	**Worsened**
Have your problems improved or worsened since then?		

	No	Yes, sometimes	Often (50% of the time or more)
Do you feel pain during sexual intercourse?	☐	☐	☐
Do you feel pain in the lower part of your spine?	☐	☐	☐
Do you feel pain in your lower abdomen?	☐	☐	☐
Do you feel pain in the front part of your vagina?	☐	☐	☐

Assessment of your quality of life

Please indicate the extent to which your incontinence problems affect your everyday life.
Please put a cross by the response, which applies.

1 = normal
2 = very little, no effect on how I lead my everyday life
3 = I can't drink anything when out and about, I must always know where the nearest toilet is
4 = I always wear incontinence pads, I participate in very few social activities
5 = I prefer to stay at home

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