Contemporary Obstetrics and Gynecology, PC

BLADDER/BOWEL
SATISFACTION SURVEY

Name_____ Date of Birth_____

Doctor _____ Today's Date_____

Do you have any issues with your bladder? **Yes** **No**

If yes, please circle which symptoms best describe you:

Frequent Urination – Day, Night, or Both
Sudden or Strong Urge to Urinate
Leaking with Urge or No Warning
Unable to Empty the Bladder
Frequent Bathroom Visits w/ Inability to Void
Leaking with Sneezing, Coughing, Exercising

Have you tried medication?

If yes, which ones (Circle all that apply):

Ditropan Enablex Detrol Toviaz Sanctura Myrbetriq Other

Do you have bowel control problems? **Yes** **No**

(If yes, Circle all that apply) Incontinence Constipation Other

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/bowel control symptoms? Circle a number.

Not Frustrated Extremely Frustrated

0 1 2 3 4 5 6 7 8 9 10

Are you interested in learning more about other treatment options for your symptoms?

Yes **No**