

Dr. med. Bettina von Seefried  
Dr. med. Juliette Schmid-Lossberg  
Gudrun Mehring  
Dr. med. Friederike Bender

Dr. med. Anna Fischer  
Dr. med. Simone Hermanns  
Dr. med. Isabella Kiefer

Dr. med. Jennifer Pohle  
Dr. med. Eftymia Konstantinidou  
Dr. med. Stephanie Preschany

Dr. med. Anne Temler  
Dr. med. univ. Martina von Watzdorf  
Dr. med. Marie-Louise Zucker

# Bladder weakness questionnaire

Dear patient,

In order to better prepare myself for our interview, please fill in the following questions:

First name, last name .....

Date of birth... ..

Address .....

Email address ..... Phone.....

Weight..... Size.....

Date .....

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1. What are the complaints?

.....  
.....  
.....

2. Since when?

.....  
.....  
.....

3. What bothers you the most?

.....  
.....  
.....

4. Have you already received medical treatment for this reason?

.....  
.....  
.....

5. What measures have been taken so far to alleviate or remedy your symptoms?  
(e.g. medication, biofeedback, single-use catheterization, physiotherapy)

.....  
.....  
.....

6. What diseases do you have?

.....  
.....  
.....

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7. Have you had abdominal or abdominal surgery?

Yes  No

If yes, which?

.....  
.....

When?.....

8. Did you give birth to children

Yes  No

If the answer is "yes", how many are needed?.....

by caesarean section?

Yes  No

9. Have you had sexual intercourse in the past 12 months?

Yes  No

And did you have any urine leakage?

Yes  No

10. Have you had urinary tract infections in the past few months?

No  Yes which?.....

If so, then how often? .....

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11. Did you have a fever while doing this?

Yes

No

12. Is it possible for you to completely empty your bladder?

Yes

No

13. Do you have to push while urinating?

Yes

No

14. Why do you usually urinate?

Urination to urinate

habit

Prevention

15. How often do you go to the toilet during the day? .....

16. In what situations do you lose urine.

to cough

Sneeze

Laugh

Leap

Walk

To run

Lifting of loads

Stand

To sit

Lie

Climb stairs

17. Do you also lose urine without noticing it right away?

Yes

No

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18. Do you have to go to the toilet immediately if you feel an urge to urinate?

- |  |   |
|--|---|
| <input type="checkbox"/> Yes immediately                         | <input type="checkbox"/> as quickly as possible (within 10 min) |
| <input type="checkbox"/> I often don't get to the toilet in time | <input type="checkbox"/> I can wait longer                      |

19. Do you sometimes have to urinate and still only get a small amount?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

20. Do you wake up at night because you feel the urge to urinate?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

21. Do you lose urine while you sleep?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

If so, do you have to go to the toilet?

- |                             |                              |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

If so, then how often? .....

22. Do you feel a burning sensation when urinating?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

23. Are there any other abnormalities that you have observed?

.....  
.....

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24. Do you use templates?

Yes

No

If so, how many per day? .....

What size or suction strength?.....

25. Do you have regular bowel movements?

No

Yes

26. Are you constipated?

No

Yes

27. Can you hold the winch?

No

Yes

28. Can you hold bowel movements?

No

Yes

29. How much do you drink roughly per day? approx. ....Litres

What do you usually drink?

Mineral water

coffee

tea

Other .....