Bladder Patient Satisfaction Survey

Patient Name: _____ Phone#: _____

Address: _____ Doctor: _____

Which symptoms best describes you? (Circle answers)

Frequent Urination-Day, Night or Both

Sudden or Strong Urge to urinate

Unable to Empty the Bladder

Leaking with sneezing, coughing, exercising

Leaking with Urge or with no warning- Unable to make it to the bathroom in time.

_____None of these symptoms apply to me

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If so, which ones have you tried?

Detrol LA	Ditropan XL	Flomax	Cardura
Oxytrol Patch	Enablex	Vesicare	DDAVP
Gelnique	Toviaz	Sanctura	Elavil
Elmiron	Other		

Did these Medications help your symptoms?

Little Relief- 1 2 3 4 5 6 7 8 9 10- Completely Cured

If you stopped your medications, Why?

Did not help Side effects Too Expensive

Explain Side effects _____

What is your level of frustration with your bladder symptoms?

Not Frustrated- 1 2 3 4 5 6 7 8 9 10- Very Frustrated

Do you experience any bowel incontinence? How frequent? Please describe.

If you were to spend the rest of your life with your condition just the way it is now, Would you be: (Please circle one) Mostly Satisfied or Disappointed?