Coombe Women & Infants University Hospital
Excellence in the Care of Women and Babies
Foirfeacht i gCúram Ban agus Naíonán

Coombe Continence Questionnaire

Name:

Address:

Date of Birth:

Age:

Number of children:

Number of Caesarean sections:

Biggest baby's birth weight:

Did you have any complications in childbirth; please specify:

Is your family complete:

What is the worst symptom that you have:

Do you leak when you:

- Cough
- Sneeze
- Exercise
- Other

On average how often do you pass urine during a 24 hour day:

On average how often do you pass urine during the night:

Have you ever wet the bed:

When you get the urge to pass urine, do you have difficulty holding on:

Do you ever leak urine because you have not been able to hold on:

Does the cold weather or the sound of running water (eg the shower) increase the urge:

Have you ever had to get out of the car to find a toilet:

After being outside the house (eg for a walk) do you ever experience an overwhelming urge to pass urine as you are opening the front door:

How often would you have an episode of incontinence:

Do you have to wear protection:

Which, if any, is worse, the incontinence caused by physical exertion (coughing, exercising etc) or that caused by not being able to hold on:

Do you have any difficulty emptying your bladder:

Are your bladder control problems interfering with your lifestyle:

On average how much fluid do you drink during the day:

Do you have history of urinary tract infections:

Do you feel thirsty regularly:

Is there a family history of Diabetes:

Do you have any difficulties with your muscle power, sensation, speech or vision:

Do you have any sensation of a prolapse of the vagina or womb (eg a bulge or a lump):

Do you have any difficulty controlling your bowel motions or wind:

Have you had any treatment for your bladder complaint:

- Physiotherapy
- Medications
- Surgery

Have you had any serious illnesses, admissions to hospital, operations:

Are you on any medications; please specify:

Do you have any allergies; please specify:

Do you smoke; if so how many cigarettes per day:

Do you drink alcohol; if so how many drinks per week:

Are there any serious medical conditions in your family:

When was your last menstrual period:

Are there any additional comments that you wish to make: