

A: RESIDENT PERSONAL DETAILS			
Name:		Date of Birth:	GP:
Aware of problem?		Assessed by:	Date:
B: CURRENT MAJOR HEALTHCARE PROBLEMS			
C: URINARY SYMPTOMS			
Frequency (times per day):		Nocturia (times per night):	
Urgency:		Average time can hang on:	
Urge Incontinence:		Stress Incontinence:	
Passive Incontinence (unaware that it is happening)?			
Nocturnal Enuresis (bedwetting)?		Nights per week:	
Dysuria (pain or burning)?		Haematuria?	
D: SYMPTOMS OF VOIDING DIFFICULTY			
Hesitancy?		Reduced stream?	
Straining to void?		Uses manual expression?	
Post-micturition (dribbling)?			
E: INCONTINENCE			
When did it start?			
Any special circumstances at onset?			
Is incontinence improving / static / worsening?			
How often does incontinence occur?			
How much is lost each time:			
If aids or pads are used, what type are they?			
Number used per day:		Number used per night:	
Are they effective?			
Type and amount of fluid intake?			
Using fluid restriction?			
Past or recent history of urinary tract infection?			
Other urinary symptoms:			
Additional Information:			
Signature: _____ Date: _____			

