

Continence Assessment Form

Personal Details

Name	Date of Birth	Height (if Known)	Weight (if Known)
Address			

Medical History (please select all that apply)

Arthritis <input type="checkbox"/>	Stroke (CVA) <input type="checkbox"/>	Diabetes Mellitus <input type="checkbox"/>	Acquired Brain Injury <input type="checkbox"/>
Hysterectomy <input type="checkbox"/>	Parkinsons Disease <input type="checkbox"/>	Fractured Hip <input type="checkbox"/>	Memory Loss <input type="checkbox"/>
Bladder Repair <input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/>	Urinary Tract Infection <input type="checkbox"/>	<input type="checkbox"/>

Other Diagnoses (please list)

Incontinence History

How long have you had a urinary problem? Was the onset sudden or gradual? Sudden
Gradual

Symptoms of the past 6 months Worsening Stable Improving Fluctuates

Have you sought help/advice before?, if yes, from whom and when?

Babies/Obstetric History

Have you given birth to any babies? Yes No (if no, please skip this section)

Did you have any problems during the birth(s)? Yes No

Please State:

Large Babies (Over 8lb 8oz) Yes No Forceps Delivery Yes No Caesarian Section Yes No

How often do you experience urinary leakage?

Never Once a Month A few times a month A few times a week Every day/night (or more)

How much urine do you lose each time?

None A few Drops A Moderate Volume A full bladder Constant dribble