

Painful Bladder

Affix patient label here

Date:

To help your doctor determine the nature of your painful bladder symptoms, please circle the number of the response to each of the questions below that best describes your situation. Please only select one response per question. You may be asked to complete this form at subsequent visits in order to reassess your symptoms at that time.

Symptoms:

Over the past month:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. How often have you felt the strong need to urinate with little or no warning?	0	1	2	3	4	5
2. Have you had to urinate less than two hours after you finished urinating?	0	1	2	3	4	5
3. Have you experienced pain or burning in your bladder?	0	1	2	3	4	5
	None	Once	Twice	3 times	4 times	5 times or more
4. How often did you most typically get up at night to urinate	0	1	2	3	4	5

Effect of symptoms:

<i>During the past month how much have each of the following been a problem for you?</i>	No Problem	Very small Problem	Small Problem	Medium Problem	Big problem
Frequent urination during the day?	0	1	2	3	4
Getting up in the night to urinate?	0	1	2	3	4
Need to urinate with little warning?	0	1	2	3	4
Burning, pain, discomfort, or pressure in your bladder	0	1	2	3	4

Total score

Symptom Problem

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To be completed by clinician

Timing of this appointment:

- Pre treatment
- 6 weeks since treatment
- 3 months since treatment
- 6 months since treatment
- 9 months since treatment
- 12 months since treatment
- >12 months since treatment
- Maintenance

Consultant Firm:

- PJG
- GSM
- CAC
- MES
- MCD

Management

Oral Treatment

- Elmiron
- Amitriptyline
- Gabapentin
- Prophylactic Antibiotic

- Other

Intravesical Treatment

- Uracyst
- Ialuril

- Other

NB: Clinicians - Please enter symptom and problem scores in notes and return completed forms in folder to the urology office for processing