METROPARTNERS OBGYN
PREMIER WOMEN'S HEALTH
OF MINNESOTA

To Our Patients:

A urodynamic study has been ordered by your physician to assist him/her in the evaluation and treatment of your condition. Urodynamic testing is done at our office listed below:

MetroPartners ObGyn
1875 Woodwinds Dr. STE 100
Woodbury, MN 55125

To schedule your urodynamic study please call 651-770-3320 option 5.

If you are taking medication for overactive bladder (ex. Detrol, Ditropan, Vesicare, etc.) stop taking the medication 2-3 days before testing.

Enclosed are several forms that we would like you to complete prior to your appointment. This information will assist the nurses in evaluating and planning your testing.

On the day of your study, empty your bladder one hour before your appointment. Then drink eight to sixteen (8-16) ounces of water. Please do not empty your bladder until instructed by the nurses in the office.

Due to the length of time allocated for your visit, if on the morning of testing you are unable to keep your appointment, please call 651-227-9141. *We reserve the right to charge a fee for appointments cancelled or broken without 24-hour notice.*

Please remember to:

Empty bladder 1 hour before the test

Drink 8 to 16 ounces of liquid

Bring the completed forms

Please bring an old pair of socks to wear during testing

FREQUENTLY ASKED QUESTIONS

What is Urodynamic testing?

A urodynamic study is a series of tests that gives your doctor information about how your bladder and urethra store and empty urine. During testing a very small catheter will be inserted into the bladder. The bladder is then slowly filled with sterile water.

Do I have to fast before the testing?

No. Eat your regular breakfast and/or lunch.

Should I take my daily medications?

Yes.

What if I have my period?

Testing can still be performed, unless flow is heavy.

Will I be able to drive my car after the testing?

Yes. There is no medicine given during the testing.

Will I be able to go to work after the testing?

Yes. There is no medicine given during the testing.

How long will the appointment take?

Allow 1 ½ hours for the visit and testing

MEDICAL HISTORY

Name:_____ Birth Date:_____ Age :_____

Doctor :_____ Height:_____ Weight:_____

Allergies:_____

_____

_____

Medications:_____

_____

_____

Over the counter meds, herbal, vitamins etc. :_____

_____

Do you currently smoke? Yes/No Packs per day:_____ How many years? _____

Have you smoked in the past? Yes/No When did you quit?_____

Please check which of the following medical problems you currently have or have had in the past.

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Injury
- ☐ Back Surgery
- ☐ Cancer
- ☐ Car Accident
- ☐ Constipation
- ☐ Diabetes
- ☐ Depression
- ☐ Diverticulitis
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Interstitial Cystitis
- ☐ Irritable Bowel
- ☐ Kidney Problems
- ☐ Low Back Pain
- ☐ Multiple Sclerosis
- ☐ Pelvic Pain
- ☐ Pulmonary Disease
- ☐ Seizures
- ☐ Stroke

Other:_____

_____

_____

List the types and dates of surgeries you have had:_____

_____

_____

_____

Number of pregnancies: _____

Number of vaginal deliveries: _____ Number of C-sections: _____

Number of episiotomies: _____ Weight of largest baby: _____

QUESTIONNAIRE

Read the following questions and circle the response that best describes your condition and how much you are bothered by:

Responses are: 0 = not at all 1 = slightly 2 = moderately 3 = greatly

1.	Frequent urination?	0	1	2	3
2.	A feeling of urgency or leakage of urine when you have urge?	0	1	2	3
3.	Urine leakage with physical activity, coughing, sneezing?	0	1	2	3
4.	Night time urination?	0	1	2	3
5.	A feeling of incomplete bladder emptying?	0	1	2	3
6.	A feeling of bulging or protrusion in the vaginal area?	0	1	2	3
7.	Pain or discomfort in the lower abdominal or genital area?	0	1	2	3
8.	Bladder problems affecting your daily activities?	0	1	2	3

1.	Does the sound or feel of running water cause you to leak urine?	Yes	No	Sometimes
2.	Do you have to rush to the bathroom when you need to pass urine?	Yes	No	Sometimes
3.	Do you feel an urge to urinate before start of leakage?	Yes	No	Sometimes
4.	Can you stop the urine when it starts to leak?	Yes	No	Sometimes
5.	Is your urgency and/or leakage worse in cold weather?	Yes	No	Sometimes
6.	Do you leak urine when coughing, laughing, or sneezing?	Yes	No	Sometimes
7.	Do you leak urine when you walk, run, or play sports?	Yes	No	Sometimes
8.	Are you wet because of constant dripping/leakage of urine?	Yes	No	Sometimes
9.	Do you have difficulty starting your urine stream?	Yes	No	Sometimes
10.	Do you strain or push when urinating?	Yes	No	Sometimes
11.	Does the urine come out slowly?	Yes	No	Sometimes
12.	Does your bladder feel empty after you urinate?	Yes	No	Sometimes
13.	Do you notice dribbling of urine after urinating?	Yes	No	Sometimes
14.	Have you wet the bed in the past year?	Yes	No	Sometimes
15.	Do you leak urine during or after sexual intercourse?	Yes	No	Sometimes
16.	Is sexual intercourse ever painful for you?	Yes	No	Sometimes
17.	Do you have pain in your bladder or lower abdomen when you are not urinating?	Yes	No	
18.	Do you experience pain or discomfort when you urinate?	Yes	No	Sometimes
19.	Do you have a burning feeling when you urinate?	Yes	No	Sometimes
20.	Have you been treated for 3 or more urinary infections?	Yes	No	

21. When was your last bladder infection? _____

22. Have you ever seen blood in your urine? Yes No

23. How often do you move your bowels? _____

24. Is your stool hard? Yes No Sometimes

25. Do you have to strain during bowel movements? Yes No Sometimes

26. Do you have to press in the vaginal area to help pass stool? Yes No Sometimes

27. Do you ever pass stool unintentionally? Yes No Sometimes

28. Do you use laxatives? Yes No Sometimes

29. If yes, what laxative. _____

30. Do you check the bathroom location when arriving at new places? Yes No Sometimes

31. When did you starting having bladder problems?

_____

32. How many times a day do you experience urinary leakage?

_____

33. How many times do you get up at night to go to the bathroom?

_____

34. Do you find it necessary to wear pads because of urine leakage?

_____

35. What type of pads do you use? (Circle) Pantiliners Full Pads Incontinence Pads

36. How many times do you change pads per day? _____

37. Do you do or have you done Kegel exercises? Yes No Sometimes

38. Have you ever had kidney stones? Yes No

39. Have you ever had your urethra dilated (stretched)? Yes No

40. Do you have a history of urine loss as a child? Yes No

as an adolescent? Yes No

after childbirth? Yes No

41. Have you been treated in the past for bladder/kidney problems? Yes No

If you answered yes please list any surgeries or medical treatment that you received.

_____

_____

_____

_____

VOIDING DIARY

Instructions

1. Keep voiding diary for a full 48 hour period.
2. Begin your diary with the first voiding upon rising in the morning.
3. A container will be provided. Measure urine in cc's.
4. Write down every time you urinate and/or leak urine.
5. Estimate how much you leak by writing down 1,2,or 3 in the leak column

   1 = damp, few drops only
   2 = wet underwear or pads
   3 = thoroughly soaked

6. Write down your activity at the time of the leak.

   Example: washing dishes, walking, sitting, laughing

7. If you had an urge to urinate before the urine leak, write YES under urge. If you felt no urgewhen the leakage occurred, write NO.
8. Record the amount and type of all liquid intake using cups or ounces. (1 cup = 8 ounces)

EXAMPLE

DATE	TIME	URINATED IN TOILET	LEAK	ACTIVITY AT TIME OF LEAK	URGE	AMOUNT & TYPE OF LIQUID INTAKE
May 20	6:15a.m	450cc				Cup of coffee
	8:00a.m.		2	Laughing	No	

Voiding Diary

DATE	TIME	URINATED IN TOILET	LEAK	ACTIVITY AT TIME OF LEAK	URGE	AMOUNT & TYPE OF LIQUID INTAKE

Voiding Diary

DATE	TIME	URINATED IN TOILET	LEAK	ACTIVITY AT TIME OF LEAK	URGE	AMOUNT & TYPE OF LIQUID INTAKE