

Athena Patient Questionnaire

Name: _____ Date of Birth: _____

Please circle Yes (Y) or No (N) answers

Please print and bring to office to discuss.

1	Do you leak urine when you laugh, cough, or sneeze?	Y / N
2	Do you leak urine when lifting something heavy?	Y / N
3	Do you use protective garments/pads in case you leak?	Y / N
4	Have you stopped running, jogging or other activities due to leakage?	Y / N
5	Have you delivered more than one baby vaginally?	Y / N
6	Do you often need to go to the bathroom more than 7 times a day?	Y / N
7	Do you frequently have a strong sudden urge to urinate?	Y / N
8	When traveling, do you have to stop often for a bathroom break?	Y / N
9	Do you get up to go to the bathroom more than twice a night?	Y / N
10	Do you have to run to the bathroom to avoid leaking?	Y / N