Risk Factors, Urodynamic Characteristics, and Distress Associated with Nocturnal Enuresis in Overactive Bladder -Wet Women

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UDS No:_________

Female Urinary Tract Symptoms Questionnaire:

This questionnaire aims to help us gain a deeper understanding of your urinary problems to compensate for the limited time during clinic visits and to enhance the effectiveness of treatment. Please fill it out with the help of your family if necessary, and bring it to us during your urodynamic study. Thank you!

A. Basic Information

1. Name: Medical Record Number:
2. Date of Birth:
3. Height: ___ cm, Weight: ___ kg. Waist Circumference: ___ cm, Hip Circumference: ___ cm, Blood Type: ___.
4. Marital Status: □ 1. Single □ 2. Married □ 3. Divorced □ 4. Widowed
5. Education Level: □ 1. Illiterate □ 2. Primary School □ 3. Middle School □ 4. High School □ 5. College or Above
6. Occupation: □ 0. Unemployed □ 1. Manual Laborer □ 2. Non-Manual Laborer
7. Number of Deliveries: ___
   Cesarean Sections: ___ Vaginal Deliveries: ___ Miscarriages: ___
8. Your current menstrual condition:
   □ 1. Regular □ 2. Irregular □ 3. Menopause

B. Main Urination Problem

What is your main urination problem during this visit? _________ How long has it been present? _________

C. Urination in the Past Month

For each statement, select the most appropriate answer.

	0 Never	1 Rarely	2 Occasionally	3 About Half the Time	4 More than Half the Time	5 Almost Always
1. I need to urinate within 2 hours during the day.	□	□	□	□	□	□
2. I feel an uncontrollable urge to urinate.	□	□	□	□	□	□
3. I feel my bladder does not empty completely.	□	□	□	□	□	□
4. I need multiple attempts to finish urinating.	□	□	□	□	□	□
5. My urine flow is weak or thin.	□	□	□	□	□	□
6. I need to strain to empty my bladder.	□	□	□	□	□	□
7. I need to squat momentarily before urinating.	□	□	□	□	□	□

8. Urine dribbles onto my underwear after urinating.	□	□	□	□	□	□
9. Full bladder causes discomfort in lower abdomen or vulva.	□	□	□	□	□	□

10. How many times do you wake to urinate at night?
    □0 time □1time □2 times □3 times □4 times □5 times or more
11. Do you experience incontinence before reaching the toilet?
    □ Never □ Rarely □ Once a Month □ Once a Week □ 2–3 Times Weekly □ Daily or More
12. Do you experience incontinence when coughing, running, or laughing?
    □ Never □ Rarely □ Once a Month □ Once a Week □ 2–3 Times Weekly □ Daily or More
13. Do you wet the bed while sleeping?
    □ Never □ Rarely □ Once a Month □ Once a Week □ 2–3 Times Weekly □ Daily or More

D. Which of the 13 urinary issues troubles you the most? Item No. ____

E. If your current urinary condition persists, how would you feel?
   □ 0. Delighted □ 1. Very Satisfied □ 2. Satisfied □ 3. Acceptable □ 4. Dissatisfied □ 5. Unhappy □ 6. Terrible

F. Reason for Consultation (Multiple Choices Allowed)
   □ 1. Concerned about illness □ 2. Quality of life/work affected □ 3. Media coverage □ 4. Family suggestion □ 5. Friend suggestion

G. Lifestyle
   1. Average sleep hours per night in the past month: ___ hours
   2. Sleep quality:
      □ 1. Very Poor □ 2. Poor □ 3. Average □ 4. Good □ 5. Very Good
   3. Exercise Habit:
      □ 0. None □ 1. Occasional □ 2. Frequent
   4. Stress from work/life:
      □ 0. None □ 1. Mild □ 2. Moderate □ 3. Severe
   5. Overall health status in the past month:
      □ 1. Very Poor □ 2. Poor □ 3. Average □ 4. Good □ 5. Very Good
   6. Alcohol Consumption:
      □ 0. None □ 1. Occasional □ 2. Frequent
   7. Smoking:
      □ 0. None □ 1. Less than one pack/week □ 2. More than one pack/week

H. Medical History：

1. Have you had any of the following conditions in the past year? (Multiple Choices Allowed)
   □ 1. Diabetes □ 2. Hypertension □ 3. Heart Disease □ 4. Chronic Lung Disease (e.g., asthma, emphysema) □ 5. Chronic Kidney Disease □ 6. Chronic Liver Disease □ 7. Neurological Issues (e.g., stroke, Parkinson's) □ 8. Mental Health Issues (e.g., anxiety, depression) □ 9. High Cholesterol □ 10. Leg Edema □ 11. Gynecological Issues □ 12. Others: _________

2. In the past year, have you taken any of the following medications regularly? (Multiple Choices Allowed)
   □ 1. Diuretics □ 2. Sleeping pills □ 3. Anti-anxiety or antidepressants □ 4. Heart or blood pressure medication □ 5. Laxatives or stool softeners □ 6. Painkillers □ 7. Asthma medication □ 8. Female hormones □ 9. Others: _________
3. In the past year, have you visited a doctor due to urinary tract or bladder infections?
   □ 0. None □ 1. Once □ 2. Twice □ 3. Three times or more
4. In the past month, have your bowel habits been normal?
   □ 0. Regular, about once every 1–2 days □ 1. Issues with constipation or difficulty passing stool □ 2. Two or more times a day
5. To your knowledge, do any of your family members have similar urinary problems?
   □ 0. No □ 1. Yes, who? ___________

I. Have your urinary problems caused any of the following difficulties?

	Not at All	A Little	Mild	Moderate	Severe
1. Feeling fatigued or lacking energy to work	□	□	□	□	□
2. Impacting activities you enjoy (e.g., hiking, running)	□	□	□	□	□
3. Being cautious about not drinking too much water	□	□	□	□	□
4. Being hesitant to go out (e.g., shopping, traveling)	□	□	□	□	□
5. Becoming nervous or anxious	□	□	□	□	□
6. Feeling frustrated or even useless	□	□	□	□	□
7. Worrying that your urinary problem will worsen	□	□	□	□	□
8. Worrying that there are no effective treatments	□	□	□	□	□
9. Worrying about affecting family members (e.g., children)	□	□	□	□	□
10. Affecting the relationship or intimacy with your partner	□	□	□	□	□