Dear Mr./Mrs. ………………………………………………….,

This questionnaire was prepared for our study titled “Can feeling of incomplete bladder emptying reflect significant postvoid residual urine? Is it reliable as a symptom solely?”. The data you provided will only be used for this study and will not be used elsewhere. Thank you for your time and accepting to participate in this study.

Prof. Dr. Zafer AYBEK, MD
Study Coordinator

PATIENT NAME AND SURNAME
Signature: …………………….
Date: …/…/201…

1. Age: ………………
2. Gender:  □ Male      □ Female
3. Do you have any illness or health problem? Please indicate:

………………………………………………………………………………………………………………………………….……

4. Do you use any medications? Please indicate the brand names.
□ No     □ Yes ……………………………………………………………………………………………………………………….

5. Did you have any operations? Please indicate the name and extent of the operation:
□ No     □ Yes ……………………………………………………………………………………………………………………….

6. Do you void too often by the day? If yes, how many times do you visit toilet until you go to bed?
□ No     □ Yes, I void too often (………times)

7. Do you wake at night to void? If yes, how many times do you wake at night to void?
□ No     □ Yes, occasionally □ Yes, every night …… times

8. Do you have a sudden compelling desire to pass urine which is difficult to defer?
□ No     □ Yes ……………………………………………………………………………………………………………………….

9. If your answer to question 8 is “Yes”, how often?
□ Everyday □ A few times in a week □ Once a week □ Less than once a week

10. Do you think that your urine flow is reduced / weak? □ No     □ Yes

11. Do you have splitting or spraying of the urine stream? □ No     □ Yes

12. Do you experience a urine flow which stops and starts, on one or more occasions, during micturition? □ No     □ Yes

13. Do you have difficulty in initiating micturition resulting in a delay in the onset of voiding after you are ready to pass urine? □ No     □ Yes

14. Do you have to use any muscular effort to either initiate, maintain or improve the urinary stream? □ No     □ Yes

15. Do you experience a prolonged final part of micturition, when the flow has slowed to a trickle/ dribble? □ No     □ Yes

16. Do you have any involuntary loss of urine immediately after you have finished passing urine, usually after leaving the toilet (in men), or after rising from the toilet (in women)? □ No     □ Yes

17. Do you have any complaints after voiding?
□ None
□ Pain after voiding
□ Burning sensation after voiding
□ Other…………………………………… (Please indicate)

18. Do you have feeling of incomplete emptying after passing urine? □ No     □ Yes

You have completed the questionnaire. Thank you…

PVR Volume (will be completed by your physician):