

Patient Experience of Urodynamics

Data Collection Sheet

Patient ID:

Age:

Gender: Male / Female

Symptoms: (please circle)

Storage LUTS

Voiding LUTS

Post Micturition LUTS

UUI

SUI

Other UI

Neurogenic LUTD? Yes / No

Was a urodynamics local or BAUS information sheet provided? Yes / No

Patient Experience:

On a scale of 1 to 5 (where 1 is not at all, 2 is a little, 3 is moderate, 4 is a lot and 5 is extremely), please circle your answer

How anxious were you before the test?

1 2 3 4 5

How anxious were you during the test?

1 2 3 4 5

How painful was the procedure?

1 2 3 4 5

How embarrassing was the procedure?

1 2 3 4 5

What was your overall satisfaction with the procedure? (tolerability for information gained)

1 2 3 4 5

If necessary, would you be willing to undergo the procedure again in the future? Yes / No

Would you recommend our unit to a friend or colleague? Yes / No

If not, why not?

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