

TANGO NOCTURIA SCREENING QUESTIONNAIRE

Age: _____ Gender: M / F How many times do you wake to void at night? _____

Please place a tick next to any statement which is TRUE for you.

<input type="checkbox"/>	My ankles, feet or legs swell during the day.	CARDIO / METABOLIC
<input type="checkbox"/>	I take fluid tablets (e.g. Lasix).	
<input type="checkbox"/>	I have kidney disease.	
<input type="checkbox"/>	I take tablets to control my blood pressure.	
<input type="checkbox"/>	I often get dizzy when standing up.	
<input type="checkbox"/>	I have high blood sugar OR diabetes.	
<input type="checkbox"/>	My blood sugar levels are difficult to keep stable.	
<input type="checkbox"/>	I have 5 hours or less sleep per night.	SLEEP
<input type="checkbox"/>	I would describe my sleep quality as <i>bad</i> .	
<input type="checkbox"/>	It takes me longer than 30 minutes to fall asleep at night.	
<input type="checkbox"/>	I have difficulty staying asleep at night because of my bladder.	
<input type="checkbox"/>	I often experience pain at night.	
<input type="checkbox"/>	I have been told I snore loudly OR stop breathing at night.	
<input type="checkbox"/>	I need to get up to pass urine within 3 hours of going to sleep.	URINARY TRACT
<input type="checkbox"/>	I experience a sudden urge to urinate on most days.	
<input type="checkbox"/>	I have a bladder urgency accident once a week or more.	
<input type="checkbox"/>	I often need to strain or push to start urinating.	
<input type="checkbox"/>	I have an enlarged prostate gland.	
<input type="checkbox"/>	In general, I would say that my health is <i>not good</i> .	WELLBEING
<input type="checkbox"/>	I have trouble staying awake while driving, eating or during social activities.	
<input type="checkbox"/>	I have had a fall in the last 3 months.	
<input type="checkbox"/>	I don't look forward to things with as much enjoyment as I used to.	