

**Incontinence Questionnaire**

**Date :** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Pre Rx**    **Post Rx**

Urogenital Distress Inventory (UDI/6)

	Not at All	Slightly	Moderately	Greatly	
<b>Do you have:</b>					
1. Frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Urine leakage related to the feeling of urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Urine leakage related to physical activity, laughing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Small amounts of urine leakage (drops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Pain or discomfort in the lower abdominal or genital area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		—	—	—	<b>Total</b> —

Incontinence Impact Questionnaire (IIQ/7)

	Not at All	Slightly	Moderately	Greatly	
<b>Has urine leakage affected your:</b>					
1. Ability to do household chores (cooking, laundry)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Physical recreation such as walking or other exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Entertainment activities (movies, concerts, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ability to travel by car or bus more than minutes from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Participation in social activities outside the house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Emotional health (nervousness depression, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Feeling frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		—	—	—	<b>Total</b> —