

____/____/____
MM DD YY

Incontinence Impact Questionnaire

Has urine leakage affected your: ("X" one for each question)

	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical recreation such as walking, swimming 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 30 minutes from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Participation in social activities outside your 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"/>

Urogenital Distress Inventory

Do you experience, and if so, How much are you bothered by: ("X" one for each question)

	Not at all	Slightly	Moderately	Greatly
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, coughing, or sneezing?	<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"/>

1. Do you have any uncontrolled leakage of gas, liquid, or solid stool?

___ Yes ___ No

If yes, mark which apply

___ gas
___ liquid stool
___ solid stool

2. On a scale of 0 to 100, where zero represents death and 100 represents perfect health, please indicate how you would rate your current state of health.

___ ___ ___ Number from 0 – 100