Ferrell-Whited Physical Therapy Services

Women's Health: Urinary Incontinence Questionnaire

Name: _____ Date: _____

Instructions: Please answer each question by circling the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

Do you experience, and if so, how much are you bothered by:	**Not at all**	**Slightly**	**Moderately**	**Greatly**
1. Frequent Urination	0	1	2	3
2. Leakage related to feeling of urgency	0	1	2	3
3. Leakage related to physical activity, coughing, or sneezing	0	1	2	3
4. Small amount of leakage (drops)	0	1	2	3
5. Difficulty emptying the bladder	0	1	2	3
6. Pain or discomfort in lower abdominal or genital area	0	1	2	3

(For Therapist use only) Score UDI-6: _____

Instructions: Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activity, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your:	**Not at all**	**Slightly**	**Moderately**	**Greatly**
1. Ability to do household chores (cooking, cleaning, laundry)	0	1	2	3
2. Physical recreation (walking, swimming, etc)	0	1	2	3
3. Entertainment activities (movies, concerts, etc)	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home	0	1	2	3
5. Participation in social activities outside your home	0	1	2	3
6. Emotional health (nervousness, depression, etc.)	0	1	2	3
7. Feeling frustrated	0	1	2	3

(For Therapist use only) Score IIQ-7: _____