



UDI / IIQ INDEX FORM

Name: _____ Date: _____

UROGENITAL DISTRESS INVENTORY (UDI 6)

Please answer **ALL** questions as best you can.

DO YOU EXPERIENCE:	No, does not occur	Yes, does not bother me	Yes, bothers me slightly	Yes, bothers me moderately	Yes, bothers me greatly
1. Frequent urination?	<input type="checkbox"/>	<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"/>	<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"/>	<input type="checkbox"/>
4. Small amounts of urine leakage (that is drops)?	<input type="checkbox"/>	<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"/>	<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"/>	<input type="checkbox"/>

INCONTINENCE IMPACT QUESTIONNAIRE (IIQ7)

Please answer **ALL** questions as best you can.

HAS URINE LEAKAGE AND/OR PROLAPSE AFFECTED YOUR:	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, cleaning, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical recreational activities such as walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Entertainment activities such as going to a movie or a concert?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ability to travel by car or bus for longer than 20 minutes from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Participating in social activities outside your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Emotional health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your problem cause you to experience frustration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>