

**Incontinence Impact Questionnaire**



**Incontinence Impact Questionnaire**

Name :

MRN :

DOB :

Encounter date:

Symptom Index	Problem Index and Quality of Life				
<b>Symptom Index</b>	Not at all	Less than half of the time	About half of the time	More than half of the time	Almost always
1. Over the past month has the leakage of urine and/or prolapse affected your ability to do household chores (cooking, housecleaning, laundry)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
2. Over the past month has the leakage of urine and/or prolapse affected your physical recreation such as walking, swimming, or other exercise?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
3. Over the past month has the leakage of urine and/or prolapse affected your ability to attend entertainment activities (movies, concerts, etc.)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
4. Over the past month has the leakage of urine and/or prolapse affected your ability to travel by car more than 30 minutes from home?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
5. Over the past month has the leakage of urine and/or prolapse affected your participation in social activities outside your home?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
6. Over the past month has the leakage of urine and/or prolapse affected your emotional health (nervousness, depression, etc.)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
7. Over the past month how many times has the leakage of urine and/or prolapse made you feel frustrated?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
<b>Score:</b>					

Completed by:

Cancel

Print & Accept

Accept

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Name :

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Symptom Index      Problem Index and Quality of Life

Do you experience, and if so, how much are you bothered by:

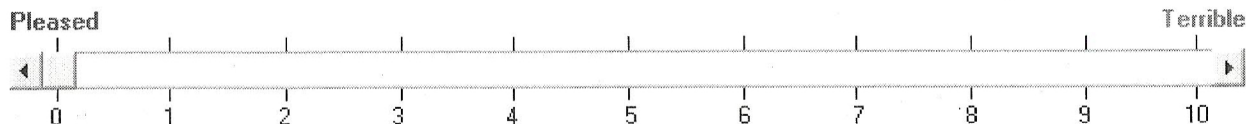
	Not at all	Slightly	Moderately	Greatly
1. Frequent urination?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Urine leakage related to the feeling of urgency (sudden desire to urinate)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Urine leakage related to physical activity, coughing, or sneezing?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Small amounts of urine leakage (drops)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Difficulty emptying your bladder?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Pain or discomfort in the lower abdominal or genital area?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

Score:

Quality of life due to urinary problems

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

Please use the scrollbar below to indicate your feelings about your urinary problem:



Completed by: