HUNTERDON UROLOGICAL ASSOCIATES
Symptom Checker

PATIENT'S NAME: __________________________ DATE OF BIRTH: _________________________

WHICH SYMPTOMS BEST DESCRIBE YOU?: *(Check all that apply)*

- ○ Cannot urinate or never completely empty bladder
- ○ Frequent urination – day, night or both
- ○ Sudden or strong urge to urinate
- ○ Leakage with little to no warning – sometimes unable to make it to the bathroom in time
- ○ Unable to completely empty the bladder – feels like there is more even after going to the bathroom
- ○ Accidental leakage with physical activity – exercising, sneezing or coughing
- ○ Bladder or pelvic pain
- ○ Accidental loss or leakage of stool – sometimes unable to make it to the bathroom in time
- ○ Bowel accidents while unaware – no warning and/or while asleep
- ○ Sudden or strong urge to have a bowel movement – sometimes resulting in accidents
- ○ No bladder or bowel problems

Have you tried medications to help your bladder or bowel symptoms (circle below)? ____Yes ____No

Detrol	Ditropan XL	Oxybutinin	Enablex	Gelnique	Oxytrol patch
Vesicare	Sanctura	Toviaz	Myrbetriq	Imodium	Other______________

BLADDER OR BOWEL SYMPTOM FRUSTRATION (circle a number)

0	1	2	3	4	5	6	7	8	9	10

Not frustrated   Extremely frustrated

PATIENT PERCEPTION OF BLADDER CONDITION (PPBC)

- ○ 1 – My bladder condition does not cause me any problems at all.
- ○ 2 – My bladder condition causes me some very minor problems.
- ○ 3 – My bladder condition causes me some minor problems.
- ○ 4 – My bladder condition causes me (some) moderate problems.
- ○ 5 – My bladder condition causes me severe problems.
- ○ 6 – My bladder condition causes me many severe problems.

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UROGENITAL DISTRESS INVENTORY – SHORT FORM (UDI-6)

Please answer each question by checking 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**
Frequent urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3

UDI-6 Total Score ______________

INCONTINENCE IMPACT QUESTIONNAIRE – SHORT FORM (IIQ-7)

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 activities, relationships, and feelings are being affected by the urine leakage.

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

IIQ-7 Total Score ______________

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