NORTH COAST UROLOGY

Female Incontinence Questionnaire

Patient Name: _____ Date: ____/____/_____

Date of Birth : ____/____/_____

Leakage of urine (incontinence) affects many women. Please answer the following questions, so we may better assess your symptoms and suggest the best treatment options. For questions 2 through 7, please consider your average symptoms over the past 4 weeks.

1. Do you leak urine? _____NO _____YES
If YES,
How many weeks/months/years have you been experiencing leaking? _____

2. Do you wear a pad everyday? _____NO _____YES
If YES,
How many pads do you wear in a day? _____

3. How many times do you get up to void in the night? _____

4. How OFTEN do you leak urine?

___never	0
___about once a week or less often	1
___two or three times a week	2
___about once a day	3
___several times a day	4
___all the time	5

5. How much urine do you leak, including leakage into a protective pad if you wear one?

___none	0
___a small amount	2
___a moderate amount	4
___a large amount	6

6. How much does urine leakage interfere with your everyday life?

0 1 2 3 4 5 6 7 8 9 **10**
never a great deal

ICIQ score: sum scores of questions 4+5+6=

7. When does urine leak?
___never. Urine does not leak
___leaks when standing up
___leaks before you can get to the toilet
___leaks when you cough or sneeze
___leaks when you are asleep
___leaks when your physically active/exercising
___leaks when you have finished urinating and are dressed
___leaks for no obvious reason
___leaks all the time