## Patient Assessment Questionnaire

### Symptoms - please tick ALL the statements that apply to you

**Stress**
- I leak when I laugh, cough, sneeze, run or jump
- I only ever leak a little
- At night, I only use the toilet once or not at all
- I always know when I have leaked
- I leak without feeling the need to empty my bladder
- Only my underwear gets wet when I leak
- I leak urine during sexual intercourse

**Urge**
- I feel the sudden urge to pass urine and have to go quickly
- I feel a strong uncontrolled need to pass urine prior to leaking
- I leak moderate amounts before I reach the toilet
- I feel that I pass urine frequently
- I get up at night to pass urine at least twice
- I think I had bladder problems as a child

**Overflow**
- I find it hard to pass urine
- I have to push or strain to pass urine
- My urine flow stops and starts several times
- My urine stream is weaker than it used to be
- I feel that it takes me a long time to empty my bladder
- I feel as if my bladder is not completely empty after I have been to the toilet
- I leak a few drops of urine on my underwear just after I have passed urine

### Personal assessment

**What type of housing do you live in?**
- House
- Flat
- Bungalow
- Residential Home
- Nursing Home

**Can you go to the toilet?**
- Without help
- With help

**Can you manage clothing?**
- Without help
- With help

**Is your laundry done by?**
- Self
- Family
- Carer
- Laundrette
- Washing machine
- Tumble dryer

**Do you?**
- Live alone
- Live with someone

**Are you able to?**
- Go out
- Can’t go out

**What toilet facilities do you have?**
- Upstairs
- Downstairs
- Commode
- Urinal
- Bed pan

**Are you?**
- Fully mobile
- Mobile with help
- Mobile with zimmer/stick

**Are you confined in any way?**
- To a bed
- Chair/wheelchair

**Who cares for you?**
- Self
- Family
- Carers

**Do you have visual or hearing problems?**
- Visual
- Hearing

**Do you wear containment products?**
- Amount per day
- Type

Please complete all relevant sections and bring this form with you to your appointment.
**Male only section**

Please circle the score most relevant to you.

1. **How often do you have a sensation of not emptying your bladder completely after you finish urinating?**
   - Never 0
   - Less than half the time 1
   - About half the time 2
   - Almost always 3
   - More than half the time 4

2. **How often do you have a weak urinary stream?**
   - Never 0
   - Less than half the time 1
   - About half the time 2
   - Almost always 3
   - More than half the time 4

3. **How often do you have to push or strain to begin urination?**
   - Never 0
   - Less than half the time 1
   - About half the time 2
   - Almost always 3
   - More than half the time 4

4. **How difficult is it to find it to postpone urination?**
   - Never 0
   - Less than half the time 1
   - About half the time 2
   - Almost always 3
   - More than half the time 4

5. **How often do you stop and start again several times when urinating?**
   - Never 0
   - Less than half the time 1
   - About half the time 2
   - Almost always 3
   - More than half the time 4

6. **How much does leaking urine interfere with your everyday life?**
   - None 0
   - A small amount 1
   - About half the time 2
   - A moderate amount 3
   - A large amount 4
   - More than half the time 5

Add together your scores from questions 1 - 6

Score = 

---

**Quality of life due to urinary symptoms**

If you were to spend the rest of your life with your condition the way it is now, how would you feel.

<table>
<thead>
<tr>
<th>Delighted</th>
<th>Pleased</th>
<th>Satisfied</th>
<th>Mixed</th>
<th>Dissatisfied</th>
<th>Unhappy</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

* International Prostate Symptom Score (IPSS)

---

**Frequency/Volume Chart** (please complete this chart for three consecutive days and nights)

Whenever you have a drink or pass urine, write down the amount consumed or passed in the appropriate boxes. Use a measuring jug to record the amount of urine passed. If you leak urine or have had to change a wet pad, add a tick in the appropriate box.

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1: Date</th>
<th>Day 2: Date</th>
<th>Day 3: Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>1 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>2 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>3 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>4 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>5 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>6 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>7 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>8 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>9 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>10 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>11 am</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>12 noon</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>1 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>2 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>3 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>4 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>5 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>6 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>7 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>8 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>9 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>10 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
<tr>
<td>11 pm</td>
<td>ml of urine</td>
<td>ml of urine</td>
<td>ml of urine</td>
</tr>
</tbody>
</table>

---

**Personal details**

Title: (Mr, Mrs, Miss, Ms) 
Full Name: 
Address: 
Date of birth: 
Postcode

---

**Female only section**

Please circle the score most relevant to you.

1. **How often do you leak urine?**
   - Never 0
   - Once a week or less 1
   - 2-3 times a week 2
   - Once a day 3
   - Several times a day 4
   - All the time 5

2. **How much urine do you usually leak?**
   - None 0
   - A small amount 1
   - About half the time 2
   - A moderate amount 3
   - A large amount 4
   - All the time 5

3. **How much does leaking urine interfere with your everyday life?**
   - Never 0
   - Less than half the time 1
   - About half the time 2
   - Almost always 3
   - More than half the time 4
   - 10 = a great deal

Add together your scores from questions 1 - 3

Score = 

---

* ICIQ - UI

---

If you leak urine or have had to change a wet pad, add a tick in the appropriate box.

---

If you were to spend the rest of your life with your condition the way it is now, how would you feel.

---

Quality of life due to urinary symptoms

If you were to spend the rest of your life with your condition the way it is now, how would you feel.

---

**Continence service use only:**

Patient NHS Number

---

Date of birth: 