Melissa Ita'aehau, DPT

_____/_____/_____ NAME: _____
MM DD YY

WASATCH PHYSICAL THERAPY
Back to life

Incontinence Impact Questionnaire

Has urine leakage affected your: ("X" one for each question)

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

Urogenital Distress Inventory

Do you experience, and if so, how much are you bothered by: ("X" one for each question)

		Not at all	Slightly	Moderately	Greatly
1.	Frequent urination?	☐	☐	☐	☐
2.	Urine leakage related to the feeling of urgency?	☐	☐	☐	☐
3.	Urine leakage related to physical activity, coughing, or sneezing?	☐	☐	☐	☐
4.	Small amounts of urine leakage drops?	☐	☐	☐	☐
5.	Difficulty emptying your bladder?	☐	☐	☐	☐
6.	Pain or discomfort in the lower abdominal or genital area?	☐	☐	☐	☐

1. Do you have any uncontrolled leakage of gas, liquid, or solid stool?
   ___ Yes ___No
   If yes, mark which apply ____ gas ____ liquid stool ____ solid stool

2. On a scale of 0 to 100, where zero represents death and 100 represents perfect health, please indicate how you would rate your current state of health. _____ Number from 0 - 100