

## INCONTINENCE QUESTIONNAIRE (UDI-6)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**DO YOU EXPERIENCE ANY URINARY INCONTINENCE?    \_\_\_ YES    \_\_\_ NO**

Please circle the number that best describes what you are feeling. Use the following as your guide.

- (0) Not at All
- (1) Slightly
- (2) Moderately
- (3) Greatly

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

1. Frequent urination? (0) (1) (2) (3)
2. Urine leakage related to the feeling of urgency? (0) (1) (2) (3)
3. Urine leakage related to physical activity, coughing, or sneezing? (0) (1) (2) (3)
4. Small amounts of urine leakage? (0) (1) (2) (3)
5. Difficulty emptying your bladder? (0) (1) (2) (3)
6. Pain or discomfort in the lower abdomen or genital area? (0) (1) (2) (3)

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**(For physician only)**

- \_\_\_\_\_ Timed Voiding
- \_\_\_\_\_ Double Voiding
- \_\_\_\_\_ Conservative Fluid Management
- \_\_\_\_\_ Kegel Exercise Program
- \_\_\_\_\_ Anti-cholinergic or Other Medical Therapy
- \_\_\_\_\_ Urodynamic Evaluation Discussed
- \_\_\_\_\_ Surgical Intervention Discussed

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_