

Name: _____ Date: _____

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Urine leakage related to the feeling of urgency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Urine leakage related to physical activity, coughing, or sneezing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Small amounts of urine leakage drops?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Pain or discomfort in the lower abdominal or genital area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Concerns

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
3. Other: _____

