

Overactive Bladder Patient Questionnaire (ICIQ-OAB) CONFIDENTIAL	Name Date Of Birth: Address: Male / Female																							
Today's Date (dd/mm/yyyy):																								
<p>Many people experience urinary symptoms some of the time. We are trying to find out how many people experience urinary symptoms, and how much they bother them.</p> <p>We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the past four weeks.</p>																								
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>1a. How often do you pass urine each day?</p> </div> <div style="width: 35%;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: right;">Every four hours or more</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">0</td> </tr> <tr> <td style="text-align: right;">every three hours</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">1</td> </tr> <tr> <td style="text-align: right;">every two hours</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">2</td> </tr> <tr> <td style="text-align: right;">hourly</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">3</td> </tr> </table> </div> </div>		Every four hours or more	<input type="checkbox"/>	0	every three hours	<input type="checkbox"/>	1	every two hours	<input type="checkbox"/>	2	hourly	<input type="checkbox"/>	3											
Every four hours or more	<input type="checkbox"/>	0																						
every three hours	<input type="checkbox"/>	1																						
every two hours	<input type="checkbox"/>	2																						
hourly	<input type="checkbox"/>	3																						
<p>1b. How much does this bother you? Please circle the number below that applies to you.</p> <table style="width: 100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td colspan="5">Not at all</td> <td colspan="6"></td> <td>A great deal</td> </tr> </table>		0	1	2	3	4	5	6	7	8	9	10	Not at all											A great deal
0	1	2	3	4	5	6	7	8	9	10														
Not at all											A great deal													
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>2a. During the night how many times do you have to get up to urinate, on average?</p> </div> <div style="width: 35%;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: right;">none</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">0</td> </tr> <tr> <td style="text-align: right;">one</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">1</td> </tr> <tr> <td style="text-align: right;">two</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">2</td> </tr> <tr> <td style="text-align: right;">three</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">3</td> </tr> <tr> <td style="text-align: right;">four or more</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">4</td> </tr> </table> </div> </div>		none	<input type="checkbox"/>	0	one	<input type="checkbox"/>	1	two	<input type="checkbox"/>	2	three	<input type="checkbox"/>	3	four or more	<input type="checkbox"/>	4								
none	<input type="checkbox"/>	0																						
one	<input type="checkbox"/>	1																						
two	<input type="checkbox"/>	2																						
three	<input type="checkbox"/>	3																						
four or more	<input type="checkbox"/>	4																						
<p>2b. How much does this bother you? Please circle the number below that applies to you.</p> <table style="width: 100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td colspan="5">Not at all</td> <td colspan="6">A great deal</td> </tr> </table>		0	1	2	3	4	5	6	7	8	9	10	Not at all					A great deal						
0	1	2	3	4	5	6	7	8	9	10														
Not at all					A great deal																			
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>3a. Do you have to rush to the toilet to urinate?</p> </div> <div style="width: 35%;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: right;">never</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">0</td> </tr> <tr> <td style="text-align: right;">occasionally</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">1</td> </tr> <tr> <td style="text-align: right;">sometimes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">2</td> </tr> <tr> <td style="text-align: right;">most of the time</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">3</td> </tr> <tr> <td style="text-align: right;">all of the time</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: left;">4</td> </tr> </table> </div> </div>		never	<input type="checkbox"/>	0	occasionally	<input type="checkbox"/>	1	sometimes	<input type="checkbox"/>	2	most of the time	<input type="checkbox"/>	3	all of the time	<input type="checkbox"/>	4								
never	<input type="checkbox"/>	0																						
occasionally	<input type="checkbox"/>	1																						
sometimes	<input type="checkbox"/>	2																						
most of the time	<input type="checkbox"/>	3																						
all of the time	<input type="checkbox"/>	4																						
<p>3b. How much does this bother you? Please circle the number below that applies to you.</p> <table style="width: 100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td colspan="5">Not at all</td> <td colspan="6">A great deal</td> </tr> </table>		0	1	2	3	4	5	6	7	8	9	10	Not at all					A great deal						
0	1	2	3	4	5	6	7	8	9	10														
Not at all					A great deal																			

<p>4a. Does urine leak before you can get to the toilet?</p>	<table style="margin-left: auto;"> <tr><td>never</td><td><input type="checkbox"/></td><td>0</td></tr> <tr><td>occasionally</td><td><input type="checkbox"/></td><td>1</td></tr> <tr><td>sometimes</td><td><input type="checkbox"/></td><td>2</td></tr> <tr><td>most of the time</td><td><input type="checkbox"/></td><td>3</td></tr> <tr><td>all of the time</td><td><input type="checkbox"/></td><td>4</td></tr> </table>	never	<input type="checkbox"/>	0	occasionally	<input type="checkbox"/>	1	sometimes	<input type="checkbox"/>	2	most of the time	<input type="checkbox"/>	3	all of the time	<input type="checkbox"/>	4								
never	<input type="checkbox"/>	0																						
occasionally	<input type="checkbox"/>	1																						
sometimes	<input type="checkbox"/>	2																						
most of the time	<input type="checkbox"/>	3																						
all of the time	<input type="checkbox"/>	4																						
<p>4b. How much does this bother you? Please circle the number below that applies to you.</p> <table style="width: 100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td colspan="5">Not at all</td> <td colspan="6"></td> <td>A great deal</td> </tr> </table>		0	1	2	3	4	5	6	7	8	9	10	Not at all											A great deal
0	1	2	3	4	5	6	7	8	9	10														
Not at all											A great deal													

For office use:	
ICIQ-OAB Total Score:	(Sum scores 1a + 2a + 3a + 4a) Score 0 (min) – 15 (max)

Thank you for completing this questionnaire.