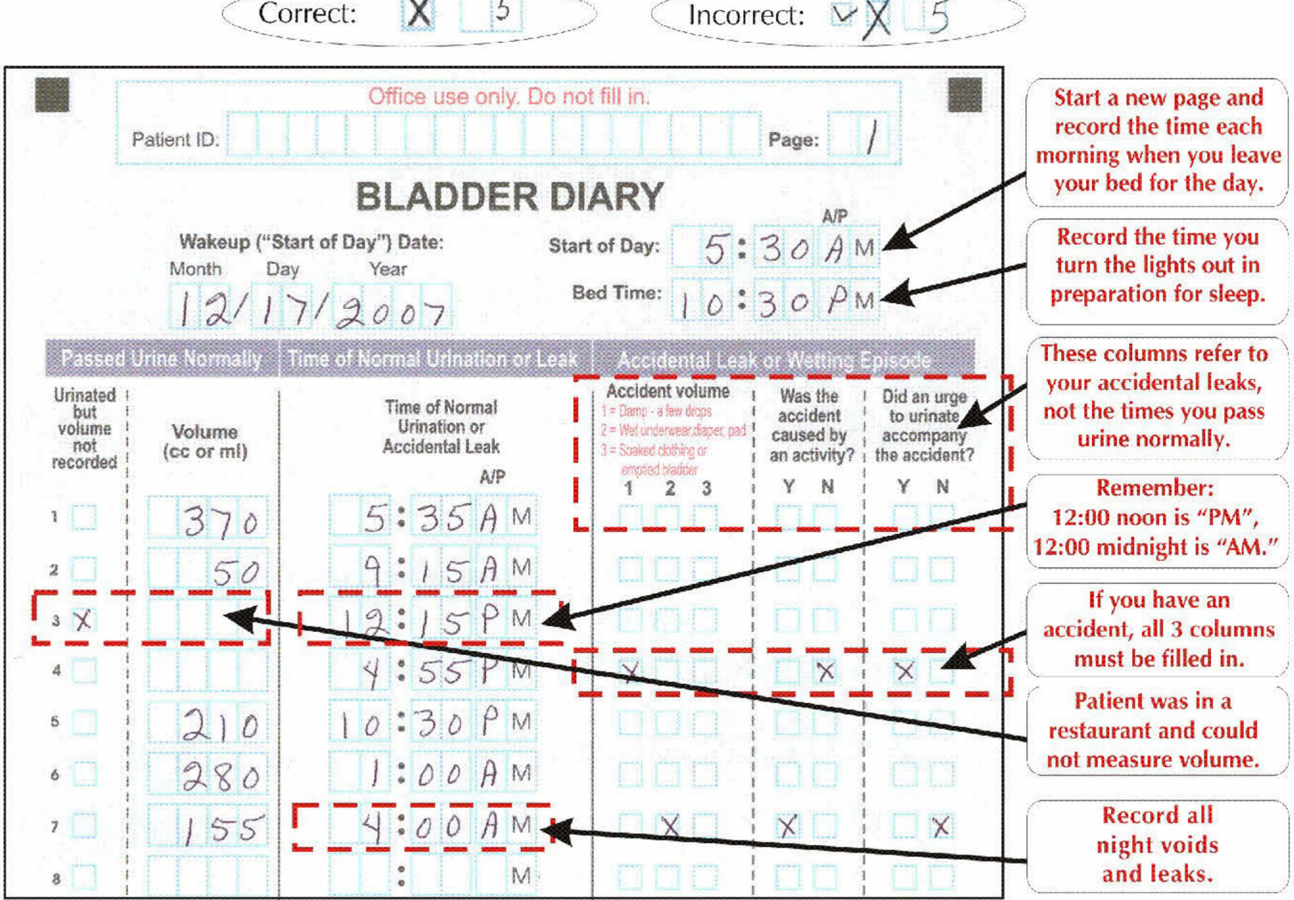
BLADDER DIARY INSTRUCTIONS

1. Keep your Diary for _______ consecutive days. Use black ink.
2. Begin on the morning of a day that you will be able to: (a) complete all days without interruption and, (b) follow your usual sleep/wake pattern.
3. "Start of Day" is the time you leave your bed for the day.
4. "Bed Time" is the time you turn the lights out in preparation for sleep.
5. The first time recorded on each sheet must be on or after your Start of Day time.
6. Use as many sheets of the Diary as needed to record all urinations or leaks from the time you wake up until you wake up the next morning. However, always begin a new sheet each time you wake up to start a new day.
7. To record a voluntary urination, measure the amount of urine you pass in cubic centimeters ((cc) or milliliters (ml) and record in the "Volume (cc/ml)" column. Use the measuring vessel provided.
8. If you are in a place (e.g. a restaurant) where you cannot measure your urine volume, just "X" the "Urinated but volume not recorded" box and record the time of the urination.
9. In the Accidental Leak or Wetting Episode columns, record how much you leaked, whether it was caused by an activity (e.g. running, lifting, walking, coughing), or whether an urge to urinate caused you to wet before you could get to the toilet. (A short dribble after a urination is not a "leak".) NOTE: These columns do not refer to your voluntary urinations. Leave them blank unless you have an accidental leak. Fill in all three columns if you have a leak.
10. Record all urinations and accidents that occur during both the night and the day.
11. If you have any questions, call ___________________________.

Correct: X 5   Incorrect: ✓X 5



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Patient ID: Page: 1

BLADDER DIARY

Wakeup ("Start of Day") Date: Month 12 / Day 17 / Year 2007

Start of Day: 5:30 AM (A/P)
Bed Time: 10:30 PM

	Passed Urine Normally		Time of Normal Urination or Leak	Accidental Leak or Wetting Episode		
	Urinated but volume not recorded	Volume (cc or ml)	Time of Normal Urination or Accidental Leak (A/P)	Accident volume (1 = Damp - a few drops; 2 = Wet underwear, diaper, pad; 3 = Soaked clothing or emptied bladder) 1 2 3	Was the accident caused by an activity? Y N	Did an urge to urinate accompany the accident? Y N
1		370	5:35 AM			
2		50	9:15 AM			
3	X		12:15 PM			
4			4:55 PM	1	N	Y
5		210	10:30 PM			
6		280	1:00 AM			
7		155	4:00 AM	2	Y	N
8			: M			

ML0054 Rev H

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BLADDER DIARY

Wakeup ("Start of Day") Date:

Month / Day / Year

Start of Day: ___ : ___ A/P M

Bed Time: ___ : ___ A/P M

Passed Urine Normally		Time of Normal Urination or Leak	Accidental Leak or Wetting Episode						
Urinated but volume not recorded	Volume (cc or ml)	Time of Normal Urination or Accidental Leak (A/P)	Accident volume 1 = Damp - a few drops 2 = Wet underwear,diaper, pad 3 = Soaked clothing or emptied bladder			Was the accident caused by an activity?		Did an urge to urinate accompany the accident?	
			1	2	3	Y	N	Y	N
1		: M							
2		: M							
3		: M							
4		: M							
5		: M							
6		: M							
7		: M							
8		: M							
9		: M							
10		: M							
11		: M							
12		: M							
13		: M							
14		: M							
15		: M							
16		: M							
17		: M							

ML0053 RevG

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Do you experience, and if so, how much are you bothered by:	Not at All 0	Slightly 1	Moderately 2	Greatly 3
1. Urine leakage related to the feeling of urgency 2. (sudden desire to urinate)?	☐	☐	☐	☐
3. Urine leakage related to physical activity, 4. coughing, or sneezing?	☐	☐	☐	☐
5. Small amounts of urine leakage (drops)?	☐	☐	☐	☐
6. Difficulty emptying your bladder?	☐	☐	☐	☐
7. Pain or discomfort in the lower abdominal or genital area?	☐	☐	☐	☐

Urogenital Distress Inventory-Short form

UDI-6 Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Quality of life due to urinary problems

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? **Please draw an "X"** across the scale below to best reflect your feelings about your urinary problem.

Pleased ☐ ☐ ☐ ☐ ☐ ☐ Terrible

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your…	Not at All 0	Slightly 1	Moderately 2	Greatly 3
1. Ability to do household chores (cooking, house cleaning, laundry)?	☐	☐	☐	☐
2. Physical recreation such as walking, swimming, or otl 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 home?	☐	☐	☐	☐
6. Emotional health (nervousness, depression, etc.)?	☐	☐	☐	☐
7. Feeling frustrated?	☐	☐	☐	☐

Incontinence Impact Questionnaire– Short Form IIQ-7

Items 1 and 2 = physical activity, 3 and 4 = travel , 5 = social/relationships, 6 and 7 = emotional health

Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

NAME: ______________________________ **DATE:** ______________________

These questions ask about symptoms you may have related to urine leakage. Please circle the number that represents how frequently you experience each symptom.

	0 Never	1 Rarely	2 Sometimes	3 Often
	☐	☐	☐	☐
Does coughing gently cause you to lose urine?	☐	☐	☐	☐
Does coughing hard cause you to lose urine?	☐	☐	☐	☐
Does sneezing cause you to lose urine?	☐	☐	☐	☐
Does lifting things cause you to lose urine?	☐	☐	☐	☐
Does bending cause you to lose urine?	☐	☐	☐	☐
Does laughing cause you to lose urine?	☐	☐	☐	☐
Does walking briskly or jogging cause you to lose urine?	☐	☐	☐	☐
Does straining, if you are constipated, cause you to lose urine?	☐	☐	☐	☐
Does getting up from a sitting to a standing position cause you to lose urine?	☐	☐	☐	☐
	☐	☐	☐	☐
Some women receive very little warning and suddenly find that they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				
If you can’t find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?	☐	☐	☐	☐
Do you lose urine when you suddenly have the feeling that your bladder is very full?	☐	☐	☐	☐
Does washing your hands cause you to lose urine?	☐	☐	☐	☐
Does cold weather cause you to lose urine?	☐	☐	☐	☐
Does drinking cold beverages cause you to lose urine?	☐	☐	☐	☐

MESA Questionnaire

<u>Urge incontinence</u>: maximum total score is 18 based on 6 questions, with a maximum score of 3 for each question.
<u>Stress incontinence</u>: maximum score is 27, based on a question with a maximum score of 3 for each question.
<u>Determine predominance</u>: urge score divided by 18 x 100 vs. stress score divided by 27 x 100

INSTRUCTIONS
Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. You may or may not have symptoms in each of these three areas, but please be sure to mark an answer in **all 3 columns** for each question. If do not have symptoms in one of these areas, then the appropriate answer would be “Not at all” in the corresponding column for each question.

EXAMPLE
For the following question:

If your bladder symptoms interfere with your ability to drive a car *moderately*, and your bowel symptoms interfere with your ability to drive a car *somewhat*, but your vaginal or pelvic symptoms do not interfere with your ability to drive a car or you have no vaginal or pelvic symptoms then you should place an X in the corresponding boxes as indicated below:

How do symptoms or conditions related to the following usually affect your ↓ →→→→	**Bladder or** ***urine***	***Bowel or rectum***	***Vagina or Pelvis***
1. ability to drive a car	☐ Not at all ☐ Somewhat ☒ Moderately ☐ Quite a bit	☐ Not at all ☒ Somewhat ☐ Moderately ☐ Quite a bit	☒ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Please make sure to answer all 3 columns for each and every question.

Thank you for your cooperation

NAME: ______________________________ **DATE:** ______________________

PLEASE REFER TO THE BACK OF THIS PAGE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM.
Pelvic Floor Impact Questionnaire – short form 7

How do symptoms or conditions related to the following usually affect your….	*Bladder or urine*	*Bowel or rectum*	*Vagina or Pelvis*
1. Ability to do household chores (cooking, house cleaning, laundry)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
2. Physical recreation such as walking, swimming, or other exercise	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
3. Entertainment activities (movies, concerts, etc.)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
4. Ability to travel by car or bus more than 30 minutes from home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
5. Participation in social activities outside your home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
7. Feeling frustrated?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit

Name:____ Date: _____________

Instructions:
Please answer these questions by putting a **X** in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these uestions, please consider your symptoms over the **last 3 months.**
Thank you for your help.

		1	2	3	4
		Not at all	**Somewhat**	**Moderately**	**Quite a bit**
1. Do you usually experience *pressure* in the lower abdomen?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
2. Do you usually experience *heaviness or dullness* in the pelvic area?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
5. Do you usually experience a feeling of incomplete bladder emptying?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
7. Do you feel you need to strain too hard to have a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
9. Do you usually lose stool beyond your control if your stool is well formed?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐

Name: ____

		1 Not at all	2 Somewhat	3 Moderately	4 Quite a bit
11. Do you usually lose gas from the rectum beyond your control?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
12. Do you usually have pain when you pass your stool?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
15. Do you usually experience frequent urination?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
16. Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
18. Do you usually experience small amounts of urine leakage (that is, drops)?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
19. Do you usually experience difficulty emptying your bladder?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐
20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	☐	☐	☐	☐

Pelvic Floor Distress Inventory – Short Form 20

Scoring:

Scores are calculated by totaling the scores for each question with 0=never, 4=always. Reverse scoring is used for items 1,2,3 and 4. The short form questionnaire can be used with up to two missing responses. To handle missing values the sum is calculated by multiplying the number of items by the mean of the answered items. If there are more than two missing responses, the short form no longer accurately predicts long form scores. Short form scores can only be reported as total or on an item basis. Although the short form reflects the content of the three factors in the long form, it is not possible to analyze data at the factor level. To compare long and short form scores multiply the short form score by 2.58 (12/31).

<u>Pelvic Organ Prolapse / Urinary Incontinence Sexual Function Questionnaire</u> (PISQ-12)

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the past <u>six months</u>. Thank you for your help.

Question					
1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, felling frustrated due to lack of sex, etc.	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
2. Do you climax (have an orgasm) when having <u>sexual intercourse</u> with your partner?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
4. How satisfied are you with the variety of sexual activities in your current sex life?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
5. Do you feel pain during sexual intercourse?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
6. Are you incontinent of urine (leak urine) with sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out?)?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
10. Does your partner have a problem with <u>erections</u> that affects your sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	Much less of the time ☐	Less intense ☐	Same intensity ☐	More intense ☐	Much more intense ☐

Name: ______________________________ Date: ______________________

Bristol Stool Form Scale

Please put a check in **a single box** next to the description that best matches your current bowel habits.

- ☐ **Type 1** Separate hard lumps, like nuts
- ☐ **Type 2** Sausage-like but lumpy
- ☐ **Type 3** Like a sausage but with cracks in the surface
- ☐ **Type 4** Like a sausage or snake, smooth and soft
- ☐ **Type 5** Soft blobs with clear-cut edges
- ☐ **Type 6** Fluffy pieces with ragged edges, a mushy stool
- ☐ **Type 7** Watery, no solid pieces

When (if ever) was your last colonoscopy and what were the results?

If you checked off a box for Type 1, Type 2, or Type 3: Have you had stool like this for 3 months or greater?

- ❑ Yes
- ❑ No

Do you have any of the following?

Yes	No	
❑	❑	Unintended weight loss greater than 10 pounds
❑	❑	Onset of constipation after the age of 50 that has not been evaluated by a colon/GI doctor
❑	❑	Family history of colon cancer
❑	❑	Anemia