

Name:

Address:

Date of birth:

VICTORIA GYNECOLOGY AND CONTINENCE CLINIC

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Urinary Incontinence Severity Score

– please check (✓) one box for each question

| | | 0 Not at all | 1 Sometimes | 2 Often |
|----|--|-----------------|----------------|------------|
| 1 | Do you experience urine leakage not related to effort or position (for example when lying down)? | | | |
| 2 | Do you experience urine leakage related to minor physical activity (for example when walking or rising)? | | | |
| 3 | Do you experience urine leakage related to strong physical activity such as coughing or sneezing? | | | |
| 4 | Has urine leakage disturbed your daily chores (shopping, cooking, housecleaning, etc.)? | | | |
| 5 | Has urine leakage disturbed your employment (client service, work performance, etc.)? | | | |
| 6 | Are you afraid others will notice your problem (fear of your odour, wetness etc.)? | | | |
| 7 | Do you have to restrict or give up social activities such as visiting friends, physical activity, theatre, church, etc.? | | | |
| 8 | Do your incontinence systems disturb your sex life? | | | |
| 9 | Does incontinence cause irritation of your external genital organs? | | | |
| 10 | How often must you use a protective napkin or pad? | | | |