Washington Urology
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Female Urinary Activity Survey
Part 1

Name: _____

Date of Birth: _____

Date Completed: _____

Patient Signature: _____

On an average day, I go to the bathroom _____ times.

On an average night, I go to the bathroom _____ times.

When I need to urinate, I feel urgency to get to the bathroom quickly. **Yes** or **No**

When I go to the bathroom, I stop and start again several times. **Yes** or **No**

When urinating, I have to strain or push to begin urination. **Yes** or **No**

After urinating, I feel that my bladder is not emptied. **Yes** or **No**

I have burning or pain when urinating. **Yes** or **No**

I have notice blood in my urine. **Yes** or **No**

When I cough, sneeze, laugh, or walk I have little control of my urination. **Yes** or **No**

If you wear protective pad(s) during the day, how many do you use on average? _____

If you wear protective pad(s) during the day, what kind are they? (Please circle all applicable.)

Panty Liners **Regular Pads** **Heavy Pads** **Depends**

Do you lose urine by continuous dribbling? **Yes** or **No**

Does your clothing become: (Please circle all applicable.)

Damp **Wet** **Soaking Wet**

Has the problem of incontinence affected your quality of life? **Yes** or **No**

Do you have any problems engaging in intimacy with your partner? **Yes** or **No**

Female Urinary Activity Survey
Part 2

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	
2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	
3. Intermittency / Dribbling Over the past month, how often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**	
	None	1 time	2 times	3 times	4 times	5 or more times	
7. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	**0**	**1**	**2**	**3**	**4**	**5**	
						TOTAL IPSS Score:	
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

I have/had burning or pain when I urinate. **Yes** or **No**

I have/had urinary tract infection (UTI) before. **Yes** or **No**

I have/had urinary leaking with urgency. **Yes** or **No**

When I use the bathroom, I have to wait a long time to begin urinating. **Yes** or **No**

I have seen blood in my urine. **Yes** or **No**

Please circle if you have/had occupational exposure to working in **paper / dying / rubber** industry.

I have/had urinary retention (the inability to urinate). **Yes** or **No**
Has the problem of incontinence affected your quality of life? **Yes** or **No**