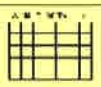
Cornwall Partnership NHS
NHS Foundation Trust

SELF-ASSESSMENT OF YOUR URINARY PROBLEMS

To help us to help you improve the bladder problems you are experiencing, it is important that you complete as much of the form as possible. This will assist the nurse to identify your particular problem.

Please take your time and feel free to contact your nurse if you have any concerns or worries about the form. The details will be treated in the strictest confidential manner.

Cornwall and Isles of Scilly Community Health Services will only use your personal information in this form for the purpose of the provision of your care and treatment. This information will be kept confidential and in accordance with the Data Protection Act 1998. We will not disclose any personal information to any other third parties, except where required by law, without your express consent other than in exceptional circumstances where the public interest outweighs the individual's rights to privacy.


Date Completed:


Surname:

Forename:


Male / 
Female *(please circle)*


Date of Birth:

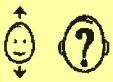

Address:

Postcode:


Contact Number: Home Work

How long have you had urinary problems?

Have you sought help or advice before? 
YES /
NO *(circle)*


If YES from whom, and when did you seek advice?

(IIQ-8)* **How has your bladder problem affected your life over the past 4 weeks?:**
(please put the relevant number in the box)

0 = not at all; 1 = slightly; 2 = moderately and 3 = greatly

		Date .....
1	Ability to do daily activities?	
2	Physical recreation such as walking, swimming, or other exercise?	
3	Entertainment activities (films, 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	Is sexual activity affected?	
7	Emotional health (nervousness, depression etc)?	
8	Feeling frustrated?	


Have you given birth to any babies?
If yes, were the births straightforward? If not please specify



How are you coping at the moment? *(e.g. more frequent visits to the toilet, wearing pads)*

Patient Name: _____ NHS Number: _____

a) How often do you leak urine?****
(please tick the box thinking how you have been on average over the past 4 weeks)

		Date .....
0	Never	
1	About once a week or less often	
2	Two or three times a week	
3	About once a day	
4	Several times a day	
5	All the time	

b) How much urine do you usually leak(whether you wear protection or not)?****
(please tick the box thinking how you have been on average over the past 4 weeks)

		Date .....
0	None	
2	A small amount	
4	A moderate amount	
6	A large amount	

c) When does urine leak?** *(please tick all that apply to you)*

Never - urine does not leak	
Leaks before you can get to the toilet	
Leaks when you cough or sneeze	
Leeks when you are asleep	
Leaks when you are physically active/exercising	
Leaks when you have finished urinating and are dressed	
Leaks for no obvious reason	
Leaks all the time	

Your medical history:

Please list any operations that you have had:

Your current medications *(include over the counter medications):*

Are you bothered by your bowel habits? *(if so, how)*

Do you have any allergies? *(if so, what are they)*

Patient Name: _____ NHS Number: _____

Do you have/need a carer?:

Mobility / Dexterity ***(please tick which ones apply to you)***

1) Able to get around easily without any help
2) Can only get around with help
3) Able to get on and off the toilet easily
4) Unable to move out of my chair without help
5) Able to dress and undress myself
6) Anything else? If so, please describe .....

.....

.....

Approximate height:

Approximate weight:

Do you smoke?:

YES / NO

If yes:

what do you smoke? .....

5 10 how many per day? .....

Drinks per 24 hours ✔ ***(please tick a box that applies to you):***

☐ 1 – 3 drinks ☐ 4 – 5 drinks ☐ 6 – 7 drinks

☐ 8 – 9 drinks ☐ 10 – 11 drinks ☐ 12 or more drinks

What do you usually drink?

What do you usually drink out of?

☐ Cup

☐ Mug

☐ Glass ☐ other

How often do you pass urine during the day, from when you get up in the morning to going to bed at night?

☐ 1 – 3 times ☐ 4 – 6 times ☐ 7 – 10 times

☐ 11 – 16 times ☐ 17 or more

How often are you woken at night by the need to pass urine?

☐ Never ☐ 1 – 2 times ☐ 3 – 4 times

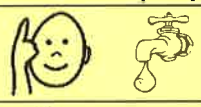
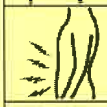
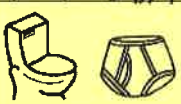
☐ 5 – 6 times ☐ 7 or more times

We want to help you improve your urinary problems. Please write down what things you want to achieve:

Patient Name: _____ NHS Number: _____

Your Symptom Profile

Please read through all the statements before ticking those most relevant for you.
Feel free to add any comments.

	1)	I leak when I laugh, cough, sneeze, run or jump	
	2)	I only ever leak a little urine	
	3)	At night, I only use the toilet once or not at all	
	4)	I always know when I have leaked	
	5)	I leak without feeling the need to empty my bladder	
	6)	Only my pants get wet when I leak	
	7)	I feel a sudden strong urge to pass urine and have to go quickly	
	8)	I feel a strong uncontrolled need to pass urine prior to leaking	
	9)	I leak moderate or large amounts before I reach the toilet	
	10)	I feel that I pass urine frequently	
	11)	I get up at night to pass urine at least twice	
	12)	I think I had bladder problems as a child	
	13)	I find it hard to start to pass urine	
	14)	I have to push or strain to pass urine	
	15)	My urine flow stops and starts several times	
	16)	My urine stream is weaker than it used to be	
	17)	I feel that it takes me a long time to empty my bladder	
	18)	I feel as if my bladder is not completely empty after I have been to the toilet	
	19)	I leak a few drops of urine on to my underwear just after I have passed urine	

* IIQ-8 = Incontinence Impact Questionnaire ** Adapted from the ICIQ-UI-SF

Acknowledgement to the Continence Care Pathway Development Group, Basingstoke who gave permission to use some of their features in this tool