BLADDER CONTROL

Overactive Bladder

Assessment Tool

Answer the questions below based on the last month. Then bring your completed assessment to your health care team. This assessment and your answers may make it easier for you to start talking about your symptoms. The questions will help measure which Overactive Bladder (OAB) symptoms you have and how much your symptoms bother you. The better your health care team knows the level and impact of your symptoms, the better they can help you manage them.

SYMPTOM QUESTIONS	Not at all	Occasionally	About once a day	About three times a day	About half the time	Almost always	SCORE
Urgency *How often do you have a strong, sudden urge to pass urine where you fear you may leak urine?*	*0**	*1*	*2*	*3*	*4*	*5*	
Urgency Incontinence *How often have you leaked urine?*	*0*	*1*	*2*	*3*	*4*	*5*	
	None	**Drops**	**1 Tea-spoon**	**1 Table-spoon**	**¼ cup**	**Entire bladder**	
Incontinence *How much urine do you think leaks?*	*0*	*1*	*2*	*3*	*4*	*5*	
	1-6 times	**7-8 times**	**9-10 times**	**11-12 times**	**13-14 times**	**15 or more times**	
Daytime Frequency *How often do you pass urine during the day?*	*0*	*1*	*2*	*3*	*4*	*5*	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	
Nighttime Frequency *How many times did you wake up to pass urine during the night?*	*0*	*1*	*2*	*3*	*4*	*5*	
SYMPTOM SCORE					Add score from right column to find total score.		

*Higher scores above may mean more severe OAB symptoms. But if your score for **Urgency** is 0, then you do not have the major symptom of Overactive Bladder.*

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Quality of Life Questions

For the quality of life questions below, please choose the response that best describes how bothered you have felt over the last month. These questions do not need to be added. This section may help show how your symptoms impact your life.

QUALITY OF LIFE QUESTIONS How much does this bother you:	I am not bothered at all					I am bothered a great deal
Urgency *– a strong, sudden urge to pass urine that makes you fear you will leak urine if you can't get to a bathroom immediately?*	*0*	*1*	*2*	*3*	*4*	*5*
Urgency Incontinence *– leaking after feeling an urge to go?*	*0*	*1*	*2*	*3*	*4*	*5*
Frequency *– passing urine frequently*	*0*	*1*	*2*	*3*	*4*	*5*
Waking *– from sleep to pass urine*	*0*	*1*	*2*	*3*	*4*	*5*
	I would not be bothered at all					**I would be bothered a great deal**
Overall Satisfaction *– If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel?*	*0*	*1*	*2*	*3*	*4*	*5*

Life Impact *– How have your symptoms changed your life? Are your symptoms:*

(Please check all that apply)

- ○ *Keeping you from getting a good night's sleep?*
- ○ *Causing you to stay home more than you would like?*
- ○ *Keeping you from social activities or entertainment?*
- ○ *Causing you to exercise less or limit your physical activity?*
- ○ *Causing problems with friends or loved ones?*
- ○ *Keeping you from traveling, taking trips, or using public transit?*
- ○ *Making you plan trips around your knowledge of public restroom locations?*
- ○ *Causing problems at work?*
- ○ *Other ways your symptoms have changed your life:*

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Quality of Life Questions help show how your symptoms impact your life to help you talk with your health care team about your symptoms. Even if you have mild symptoms, you can talk about treatment options available to you.

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