UROGENITAL DISTRESS INVENTORY

NAME_____ DATE_____/_____/_____

Please indicate whether or not you experience any of the conditions below by checking “Yes” or “No”. If “Yes”, please also check how much the condition bothers you.

Do you experience any of the following conditions?		No	Yes	If yes, how much does it bother you?			
				Not at all	Slightly	Moderately	Greatly
1.	Frequent urination	☐	☐	☐	☐	☐	☐
2.	Nighttime urination	☐	☐	☐	☐	☐	☐
3.	Urine leakage related to the feeling of urgency	☐	☐	☐	☐	☐	☐
4.	Urine leakage related to physical activity, coughing, or sneezing	☐	☐	☐	☐	☐	☐
5.	General urine leakage not related to urgency or activity	☐	☐	☐	☐	☐	☐
6.	Small amounts of urine leakage (drops)	☐	☐	☐	☐	☐	☐
7.	Large amounts of urine leakage	☐	☐	☐	☐	☐	☐
8.	Difficulty emptying your bladder	☐	☐	☐	☐	☐	☐
9.	Pain or discomfort in the lower abdominal or groin region	☐	☐	☐	☐	☐	☐