

Overactive Bladder Questionnaire

Name: _____ PID# _____ Date _____

For the following questions, please put a check below the response which best describes your bladder symptoms over the past 7 DAYS.

1. During the day, how often did you feel that you had to urinate right away?
 None of the time Some of the time Most of the time All of the time
(1-3 times per day) (4-7 times per day) (8+ times per day)
2. How often have you had urinary accidents/leakage?
 None of the time Some of the time Most of the time All of the time
(1-3 times per day) (4-7 times per day) (8+ times per day)
3. During the day, how strong was the feeling that you needed to urinate right away?
 Not strong at all A little strong Moderately strong Extremely strong
4. On an average day, how much time passed between bathroom trips?
 3 hours or more 2-3 hours 1-2 hours Less than an hour
5. On an average night, how many times did you wake up with an urge to urinate?
 0-1 2-3 4-5 6 or more
6. How much have your activities with friends and family been limited by your bladder symptoms?
 Not at all A little Moderately Extremely
7. How much has your ability to work outside the home been limited by your bladder symptoms?
 Not at all A little Moderately Extremely
8. Overall, how bothered are you with your bladder symptoms?
 Not bothered at all A little bothered Moderately bothered Extremely bothered