UDI-6 Questionnaire

Date: _____ Name: _____

Do you experience, and if so, how much are you bothered by:

	Not at all	Slightly	Moderately	Greatly
1. Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
2. Urine leakage related to the feeling of urgency? (sudden desire to urinate)	☐ 0	☐ 1	☐ 2	☐ 3
3. Urine leakage related to physical activity, coughing, or sneezing?	☐ 0	☐ 1	☐ 2	☐ 3
4. Small amounts of urine leakage (drops)?	☐ 0	☐ 1	☐ 2	☐ 3
5. Difficulty emptying your bladder?	☐ 0	☐ 1	☐ 2	☐ 3
6. Pain or discomfort in the lower abdominal or genital area?	☐ 0	☐ 1	☐ 2	☐ 3

Quality of life due to urinary problems

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?

Please check the box on the scale to best reflect your feelings about your urinary problem.