

## Painful Bladder Syndrome Questionnaire

Name

Date of Birth

Treatments

### IC symptom index

*During the past month:*

**Q1.** How often have you felt the strong need to urinate with little or no warning?

- 0.  Not at all
- 1.  Less than 1 time in 5
- 2.  Less than half the time
- 3.  About half the time
- 4.  More than half the time
- 5.  Almost always

**Q2.** Have you had to urinate less than 2 hours after you finished urinating?

- 0.  Not at all
- 1.  Less than 1 time in 5
- 2.  Less than half the time
- 3.  About half the time
- 4.  More than half the time
- 5.  Almost always

**Q3.** How often did you most typically get up at night to urinate?

- 0.  None
- 1.  Once
- 2.  2 times
- 3.  3 times
- 4.  4 times
- 5.  5 or more times

**Q4.** Have you experienced pain or burning in your bladder?

- 0.  Not at all
- 2.  A few times
- 3.  Almost always
- 4.  Fairly often
- 5.  Usually

Add the numerical values of the checked entries; total score:

### IC problem index

*During the past month how much has each of the following been a problem for you:*

**Q1.** Frequent urination during the day?

- 0.  No problem
- 1.  Very small problem
- 2.  Small problem
- 3.  Medium problem
- 4.  Big problem

**Q2.** Getting up at night to urinate?

- 0.  No problem
- 1.  Very small problem
- 2.  Small problem
- 3.  Medium problem
- 4.  Big problem

**Q3.** Need to urinate with little warning?

- 0.  No problem
- 1.  Very small problem
- 2.  Small problem
- 3.  Medium problem
- 4.  Big problem

**Q4.** Burning, pain, discomfort, or pressure in your bladder?

- 0.  No problem
- 1.  Very small problem
- 2.  Small problem
- 3.  Medium problem
- 4.  Big problem

Add the numerical values of the checked entries; total score: