

Name

Date

Male Incontinence Questionnaire

- | | | |
|---|-----|----|
| 1. Are you able to void at the toilet? ----- | Yes | No |
| 2. Is the urge to void present? ----- | Yes | No |
| 3. Is there pain or burning when you void? ----- | Yes | No |
| 4. Is it difficult to start your urine flow?----- | Yes | No |
| 5. Do you have a weak stream?----- | Yes | No |
| 6. Do you lose urine when you? | | |
| a. Have a strong urge? ----- | Yes | No |
| b. See, hear or feel water?----- | Yes | No |
| c. Move from sit to stand? ----- | Yes | No |
| d. Lift heavy objects?----- | Yes | No |
| e. Sneeze, cough or laugh?----- | Yes | No |
| f. Walk, run or exercise?----- | Yes | No |
| g. Sleep?----- | Yes | No |
| h. Other----- | Yes | No |

7. Do you experience dribbling after voiding? -----Yes No

8. How many pads/ diapers each day? _____

9. Are your pads thick or thin? _____

10. Are they damp, wet or soaked when changed? _____

11. How many times do you get up at night to void? _____

12. How many pads do you wear through the night? _____

If so, are they damp, wet or soaked when changed? _____

This section is filled by therapist:

Risk Factors _____

Total Score _____

Clinician Signature: _____

Date: _____