OAB-q Questionnaire

Patient Name: **Date of Birth:** **Today's Date:**

Determine your OAB Symptoms Circle your answers and add up your scores at the bottom.

Please complete <u>each</u> of the three sections. There are no right or wrong answers.

SECTION ONE:

During the past 4 weeks, how bothered were you by…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**A great deal**	**A very great deal**
Uncomfortable urination?	1	2	3	4	5	6
A sudden urge to urinate with little or no warning?	1	2	3	4	5	6
Accidental loss of small amounts of urine?	1	2	3	4	5	6
Nighttime urination?	1	2	3	4	5	6
Waking up at night because you had to urinate?	1	2	3	4	5	6
Urine loss associated with a strong desire to urinate?	1	2	3	4	5	6
Add Symptom Scores:	+	+	+	+	+	

Total = _____

SECTION TWO:

Quality of Life (QoL)	**Delighted**	**Pleased**	**Mostly satisfied**	**Mixed**	**Mostly dissatisfied**	**Unhappy**	**Terrible**
If you spent the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

SECTION THREE:

Treatment		
Would you be interested in treatment options?	**Yes**	**No**

Regardless of the score, if your symptoms are bothersome notify your doctor.