

# 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 each 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	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
<b>Add Symptom Scores:</b>	+	+	+	+	+	+

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

## SECTION FOUR:

Fecal Issues		
Do you leak stool or have fecal urgency?	Yes	No

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