

Interstitial Cystitis Questionnaire

Name _____ DOB _____

For each question below, please circle the answer that best describes how you feel. Then, mark your score (0-4) for each answer in the column on the right. When you are finished, add up the numbers in this column for your total score.

	0	1	2	3	4	SCORE
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+	
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+	
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe		
3. Are you currently sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If you are not sexually active, skip questions 4a and 4b.</i>						
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always		
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always		
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra or perineum)? <i>If you do not have pain, skip questions 6a and 6b.</i>	Never	Occasionally	Usually	Always		
6a. If you have pain, how would you describe it?	No Pain	Mild	Moderate	Severe		
6b. Does your pain bother you?	Never	Occasionally	Usually	Always		
7. Do you have urgency after going to the bathroom? <i>If you do not have urgency, skip questions 8a and 8b.</i>	Never	Occasionally	Usually	Always		
8a. If you have urgency, how would you describe it?	No Urgency	Mild	Moderate	Severe		
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always		

TOTAL _____