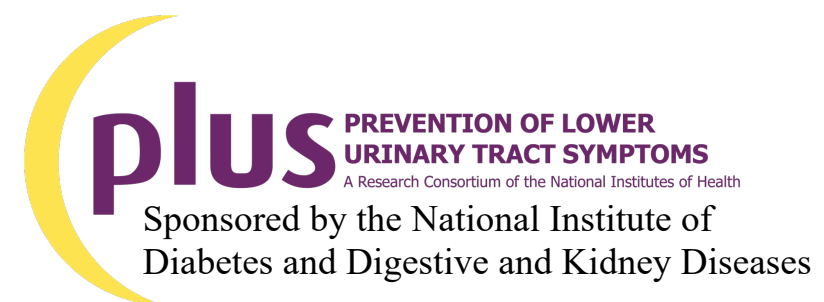




Women's Health Survey

Conducted by
Coordinating Centers for Biometric Research
at the University of Minnesota



SECTION A: GENERAL HEALTH

A1 Overall, how would you rate your well being?

- Excellent
- Very good
- Good
- Fair
- Poor

A2 Taken all together, how would you say things are these days - would you say that your life is very enjoyable, pretty enjoyable, or not too enjoyable?

- Very enjoyable
- Pretty enjoyable
- Not too enjoyable

A3 In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

A4 How is your health, compared with others your age?

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

A5 Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

A6 How often do you wake up feeling refreshed and well rested?

- Almost never
- Rarely
- Sometimes
- Usually
- Almost always

A7 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Have you felt full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A8 How much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A9

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
a. To what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How much did pain interfere with your normal work (including both work outside the home and housework)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

T12 Have you ever been pregnant?

- No → Skip to **T13**
- Yes ↴

Number of pregnancies:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Number of births:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

If 1 or more births:

Number of vaginal deliveries:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Number of caesarian deliveries:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Your age at first baby's birth:

<input type="text"/>	<input type="text"/>
----------------------	----------------------

years old

T13 Have you ever smoked at least 100 cigarettes in your ENTIRE LIFE?

- Yes → Go to **T13a**
- No
- Don't know

T13a Do you NOW smoke cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all
- Don't know

T7 Have you ever had any of the following surgical procedures?

- Surgery for urine leakage
- Hysterectomy (removal of uterus)
- Removal of bladder tumor
- Removal of ovaries
- Kidney transplant
- Urethral surgery
- Radiation to the pelvis
- Surgery for pelvic prolapse (dropped bladder, uterus, rectum)

T8 Are you currently taking any prescription medication for incontinence or bladder leaks, overactive bladder, or UTI?

- No → Skip to **T9**
- Yes → Please check the box next to any medications you are currently taking:
 - Hormone replacement
 - Vaginal estrogen
 - Medication for urine leakage
 - Antibiotics to prevent UTI

T9 Are you currently taking a diuretic or "water pill" for either high blood pressure, swelling, or any other reason?

- No
- Yes
- Don't know

T10 Have you ever heard of Kegel exercises?

- No → Skip to **T11**
- Yes → Do you do Kegel exercises?
 - No → Skip to **T11**
 - Yes → Have you ever received instruction on how to do a Kegel exercise?
 - No
 - Yes

T11 Has a doctor, nurse, or therapist ever taught you how to do pelvic floor muscle exercises with or without biofeedback?

- No
- Yes

A10 How much problem or difficulty do you have doing the following:

CAN'T DO IT AT ALL				NO PROBLEM AT ALL			
0	1	2	3	4	5	6	7

- a. Vigorous physical activities:
 - ♦Hard physical work such as lifting or carrying heavy objects (over 25 pounds) or exercise such as cross-fit, weightlifting, long distance running, etc.
- b. Moderate physical activities:
 - ♦Moderate physical work, such as lifting or carrying things that weigh 5 to 25 pounds (e.g., a heavy bag of groceries, etc.) or exercise such as dancing, jogging, Zumba, aerobics, etc.
- c. Light physical activities:
 - ♦Lifting or carrying things that weigh under 5 pounds or exercise such as stretching, yoga, walking, etc.

A11 Do you have any of these side effects from medications and/or supplements you take?

(If you do not take any medications or supplements, check this box and skip to **Section B.**)

- | | NO | YES |
|---|--------------------------|--------------------------|
| a. Muscles/movement (stiffness, aches, shaking, feel jittery, etc.). | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Peeing/urine (such as peeing more or less often, urine color/odor, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Sleep (sleeping a lot, trouble getting to sleep, waking up, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Appetite/weight (gain or loss) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Fatigue (feeling tired, hard to concentrate) | <input type="checkbox"/> | <input type="checkbox"/> |

When answering the rest of the questions in this survey, please include these side effects even if it is a side effect of a medication or supplement.

SECTION B: GENERAL BLADDER HEALTH & PERFORMANCE

B1 When was the last time you thought about your bladder?

- Hardly ever, I can't remember the last time
- In the past hour
- Within the past few hours
- At least once today
- Within the past week
- At least a month or longer

B2 Which of the following best captures how you feel about your bladder?

- It should be in the Bladder Hall of Fame
- I have a good one
- It works well enough
- It's not great
- I wish I could return it
- I got a lemon/I want a new one

B3 How strongly do you agree with the following statement:

A healthy bladder is a bladder you don't think about.

- Strongly Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

B4 My bladder is...

- No bother at all
- A little bothersome
- Somewhat bothersome
- Very bothersome
- A constant bother

SECTION T: MEDICAL BACKGROUND

T1 What is your height?

--	--

 Feet

--	--

 Inches

T2 What is your weight?

--	--	--

 Pounds

T3 Has a health care provider ever told you that you have any of the following:

- Sleep apnea
- Diabetes
- High blood pressure
- Depression
- Asthma/Chronic lung disease

T4 Has a healthcare provider ever told you that you have any of the following:

- Bladder cancer
- Pelvic organ prolapse, dropped bladder, or uterus
- Interstitial cystitis
- Accidental bowel leakage

T5 Has a healthcare provider ever told you that you have any of the following:

- Cerebral palsy
- Parkinson's disease
- Multiple sclerosis
- Spinal cord injury
- Stroke
- Spina bifida

T6 Have you ever used/had/been treated with any of the following?

- Pessary or Impressa
- Botox in the bladder
- Current dialysis
- Bladder pacemaker/nerve stimulation

S4a How many days per week do you do these moderate activities for at least 10 minutes at a time?

Days per week

Do not do any moderate physical activity for at least 10 minutes at a time → Skip to **S5**

Don't know/Not sure → Skip to **S5**

S4b On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

Hours per day and

Minutes per day

Don't know/Not sure

S5 Now, thinking about the vigorous activities you do in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?

Yes

No → Skip to **Section T**

Don't know/Not sure → Skip to **Section T**

S5a How many days per week do you do these vigorous activities for at least 10 minutes at a time?

Days per week

Do not do any vigorous physical activity for at least 10 minutes at a time → Skip to **Section T**

Don't know/Not sure → Skip to **Section T**

S5b On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

Hours per day and

Minutes per day

Don't know/Not sure

B5 How would you rate the function of your bladder?

Excellent

Very Good

Good

Fair

Poor

Terrible

B6 Compared with others your age, is your bladder function...

Much better

Somewhat better

About the same

Somewhat worse

Much worse

B7 Compared to a year ago, is your bladder function...

Much better now

Somewhat better now

About the same

Somewhat worse now

Much worse now

B8 When you laugh, cough, or sneeze do you ever leak even a few drops of urine/pee?

No, it has never happened

Yes, but very rarely

Yes, rarely

Yes, sometimes

Yes, often

Yes, all the time

B9 Usually, I feel like my bladder is the size of...

1

A Pea

2

3

4

5

6

A Watermelon

7

B10 In the past month, how often did you wake up during the night and have trouble getting back to sleep?

- Every night
- Almost always, several nights a week
- Often, at least once a week
- Sometimes, several times a month
- Rarely, less than once a month
- Never → Skip to **B11**

B10a How often is this due to your bladder, such as needing to get up to pee or feeling discomfort?

- Never
- Rarely
- Sometimes
- Often
- Every time

B11 Which best describes your getting to the bathroom in the morning?

- I have no problem holding it until I get to the bathroom
- I worry about whether I can hold it until I get to the bathroom although I always make it
- I can't always hold it until I get to the bathroom
- I usually can't hold it until I get to the bathroom
- I can never hold it until I get to the bathroom

B12 When you feel the need to pee, once you get to the bathroom how well does "getting done what you need to do" happen for you?

- I am just in and out and on with my day
- I take care of things pretty well
- It can be more of a chore than I would like
- I dread when I need to pee

B13 When it comes to my bladder...

- | | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| IT CONTROLS ME | | | IT IS A GIVE AND TAKE
RELATIONSHIP | | | | I CONTROL IT | | | |

SECTION S: WHEN YOU PEE & PHYSICAL ACTIVITY

S1 Is there a delay before you can start to urinate?

- Never
- Occasionally: Less than one third of the time
- Sometimes: Between one and two thirds of the time
- Most of the time: More than two thirds of the time
- All of the time

Bristol Female Lower Urinary Tract
Symptoms (BFLUTS) Questionnaire

S1-S3

S2 Do you have to strain to urinate?

- Never
- Occasionally: Less than one third of the time
- Sometimes: Between one and two thirds of the time
- Most of the time: More than two thirds of the time
- All of the time

S3 Do you stop and start more than once while you urinate?

- Never
- Occasionally: Less than one third of the time
- Sometimes: Between one and two thirds of the time
- Most of the time: More than two thirds of the time
- All of the time

We are interested in two types of physical activity - vigorous and moderate. Vigorous activities cause large increases in breathing or heart rate while moderate activities cause small increases in breathing or heart rate.

S4 Now, thinking about the moderate activities you do in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate?

- Yes
- No → Skip to **S5**
- Don't know/Not sure → Skip to **S5**

Behavioral Risk Factor Surveillance System
(BRFSS) Exercise questions
(S4-S5)

SECTION C: YOUR BLADDER AND GENERAL DAY TO DAY

	NO NOT PRESENT	YES If yes, how much does it bother you?			
		NOT AT ALL	SOMEWHAT	MODERATELY	QUITE A BIT
Do you usually experience frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience urine leakage related to coughing, sneezing, or laughing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience small amounts of urine leakage (that is, drops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C1 Which of the following best describes you...

I don't think about my bladder, outside of it letting me know that I need to pee → Answer **C1a**

I think about or plan some things around my bladder, such as limiting how much or what I drink, knowing where bathrooms are, always use bathroom before I leave the house, etc. → Skip to **C2**

Somewhere between option 1 and 2 → Skip to **C2**

C1a Has there ever been a time in your life when your bladder interfered with your day to day activities, no matter how minor?

No, not even once → Skip to **Section E**

Yes, it has happened at least once or twice recently → Go to **C2**

Yes, it has happened at least once or twice in the past, but not recently → Skip to **Section D**

C2 How easy or difficult are each of the following?

	VERY EASY	EASY	SOMEWHAT EASY	SOMEWHAT DIFFICULT	DIFFICULT	VERY DIFFICULT
a. When you feel the need to pee, how easy or difficult is it to hold it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. When you feel the need to pee, how easy or difficult is it to start peeing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. When you pee, how easy or difficult is it to completely empty your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C3 How often have you had any of the following problems with your work or other regular daily activities as a result of your bladder?

	NONE OF THE TIME	A LITTLE OF THE TIME	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C4 How much does your bladder impact each of the following, with 0 being no impact and 7 being dramatic negative impact?

	NO IMPACT				DRAMATIC NEGATIVE IMPACT			
	0	1	2	3	4	5	6	7
a. Your ability to enjoy life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How you feel about your overall health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How you feel about yourself as a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Your life in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C5 Thinking about the most recent time your bladder affected you, how long did this last?

- A day or two
- A week
- A month or two
- The past 6 months
- The past year
- Longer than that

C6 Have you ever stopped doing things you enjoy, even if for just a short period of time, because of your bladder?

- No, it never stopped me from doing things I enjoy → Skip to **C7**
- Yes, I stopped doing one or two things
- Yes, I stopped doing three or four things
- Yes, I stopped doing many things

C6a When was the most recent time you stopped doing something you enjoy because of your bladder?

- Within the past month
- Within the past few months
- Within the past six months
- Longer than that

SECTION R: YOUR PELVIC FLOOR

Pelvic Floor Distress Inventory (PFDI)

Instructions: The following questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by checking the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

	NO	YES			
	NOT PRESENT	NOT AT ALL	SOMEWHAT	MODERATELY	QUITE A BIT
Do you usually experience pressure in the lower abdomen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience heaviness or dullness in the pelvic area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NO	YES			
	NOT PRESENT	If yes, how much does it bother you?			
		NOT AT ALL	SOMEWHAT	MODERATELY	QUITE A BIT
Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually lose stool beyond your control if your stool is loose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually lose gas from the rectum beyond your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually have pain when you pass your stool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We would like to know what your bladder problems are and how much they affect you. From the list below, choose only those problems that you have at present. Leave out those that don't apply to you.

How much do they affect you?

FREQUENCY: going to the toilet very often

A little

Moderately

A lot

NOCTURIA: getting up at night to pass urine

A little

Moderately

A lot

URGENCY: a strong and difficult to control desire to pass urine

A little

Moderately

A lot

URGE INCONTINENCE: urinary leakage associated with a strong desire to pass urine

A little

Moderately

A lot

STRESS INCONTINENCE: urinary leakage associated with physical activity, e.g., coughing, running

A little

Moderately

A lot

NOCTURNAL ENURESIS: wetting the bed at night

A little

Moderately

A lot

INTERCOURSE INCONTINENCE: urinary leakage with sexual intercourse

A little

Moderately

A lot

BLADDER INFECTIONS OR UTIs

A little

Moderately

A lot

BLADDER PAIN

A little

Moderately

A lot

C7 My bladder is...

- No bother at all
- A little bothersome
- Somewhat bothersome
- Very bothersome
- A constant bother

C8 Have there been times in your life when your bladder interfered with your life more than it does now?

- No, never → Skip to **Section E**
- Yes, but not recently → Answer **C8a**

C8a At its worst, how much did your bladder affect each of the following:

	NOT AT ALL	A LITTLE	SOME	A LOT
a. I accomplished less than I would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I was limited in the kind of work or other activities I could do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I had to cut down on the amount of time I spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

→ Skip to **Section E**

SECTION D: YOUR BLADDER IN THE PAST

D1 While your bladder doesn't currently affect you, you indicated that it has in the past. During the time when your bladder was at its worst, how often did you have any of the following problems with your work or other regular daily activities as a result of your bladder?

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D2 During the time when your bladder affected you the most, how much did your bladder impact each of the following, with 0 being no impact and 7 being dramatic negative impact?

	NO IMPACT				DRAMATIC NEGATIVE IMPACT			
	0	1	2	3	4	5	6	7
a. Your ability to enjoy life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How you feel about your overall health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How you feel about yourself as a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Your life in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D3 Have you ever stopped doing things you enjoy, even if for just a short period of time, because of your bladder?

- No, it never stopped me from doing things I enjoy → Skip to **D4**
- Yes, I stopped doing one or two things
- Yes, I stopped doing three or four things
- Yes, I stopped doing many things

D3a When was the most recent time you stopped doing something you enjoy because of your bladder?

- Within the past 6 months
- Within the past year
- Within the past couple of years
- Longer than that

Q5

	NOT APPLICABLE	NOT AT ALL	SLIGHTLY	MODERATELY	A LOT
a. Does your bladder problem affect your relationship with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Does your bladder problem affect your sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Does your bladder problem affect your family life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q6

	NOT AT ALL	SLIGHTLY	MODERATELY	VERY MUCH
a. Does your bladder problem make you feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Does your bladder problem make you feel anxious or nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Does your bladder problem make you feel bad about yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q7

	NEVER	SOMETIMES	OFTEN	ALL THE TIME
a. Does your bladder problem affect your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Does your bladder problem make you feel worn out and tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q8 Do you do any of the following? **If so, how often?**

	NEVER	SOMETIMES	OFTEN	ALL THE TIME
a. Wear pads to keep dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Be careful how much fluid you drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Change your underclothes because they get wet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Worry in case you smell?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q1 How would you describe your health at the present? Please check one answer.

- Very Good
- Good
- Fair
- Poor
- Very Poor

Q2 How much do you think your bladder problem affects your life? Please check one answer.

- Not at all
- A little
- Moderately
- A lot

Below are some daily activities that can be affected by bladder problems. How much does your bladder problem affect you?

We would like you to answer every question. Simply check the box that applies to you.

Q3	[NOT AT ALL	SLIGHTLY	MODERATELY	A LOT]
a. Does your bladder problem affect your household tasks? (cleaning, shopping, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Does your bladder problem affect your job or your normal daily activities outside the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4	[NOT AT ALL	SLIGHTLY	MODERATELY	A LOT]
a. Does your bladder problem affect your physical activities (e.g., going for a walk, running, sport, gym, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Does your bladder problem affect your ability to travel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Does your bladder problem limit your social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Does your bladder problem limit your ability to see and visit friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D4 In the past when your bladder affected you the most, how long did that last?

- A day or two
- A week
- A month or two
- At least 6 months
- At least a year
- Longer than that

D5 At its worst my bladder was...

- No bother at all
- A little bothersome
- Somewhat bothersome
- Very bothersome
- A constant bother

D6 At its worst how much did your bladder affect each of the following:

	[NOT AT ALL	A LITTLE	SOME	A LOT]
a. I accomplished less than I would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I was limited in the kind of work or other activities I could do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I had to cut down on the amount of time I spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION E: YOUR BLADDER & SPECIFIC ACTIVITIES

E1 Due to your bladder, how much difficulty do you currently have with the following types of physical activity?

CAN'T DO IT AT ALL DUE TO MY BLADDER					NO PROBLEM AT ALL		
0	1	2	3	4	5	6	7

- a. Vigorous physical activities that your bladder interferes with:
♦Hard physical work such as lifting or carrying heavy objects (over 25 pounds) or exercise such as cross-fit, weightlifting, long distance running, etc.
- b. Moderate physical activities that your bladder interferes with:
♦Moderate physical work, such as lifting or carrying things that weight 5 to 25 pounds (e.g., a heavy bag of groceries, etc.) or exercise such as dancing, jogging, Zumba, aerobics, etc.
- c. Light physical activities that your bladder interferes with:
♦Lifting or carrying things that weigh under 5 pounds or exercise such as stretching, yoga, walking, etc.

E2 How much do you think about your bladder with each of the following types of travel?

NOT AT ALL	A LITTLE BIT	SOME	A LOT	ALL THE TIME	MY BLADDER PREVENTS ME FROM DOING THIS	NOT APPLICABLE
------------	--------------	------	-------	--------------	--	----------------

- a. Getting around town using your own car (running errands, getting to work, etc.)
- b. Getting around town using public transportation (bus, light rail, train) to run errands, get to work, etc.
- c. Long distance traveling in your own car
- d. Long distance traveling by plane, train, or bus

SECTION P: LIFE OVERALL

Please respond to each question or statement by marking one box per row.

Lately...

	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
--	-------	--------	-----------	-------	--------

- a. I had a sense of well-being
- b. I felt hopeful
- c. My life was satisfying
- d. My life had purpose
- e. My life had meaning
- f. I felt cheerful
- g. My life was worth living
- h. I had a sense of balance in my life
- i. Many areas of my life were interesting to me
- j. I was able to enjoy life
- k. I felt a sense of purpose in my life
- l. I could laugh and see the humor in situations
- m. I was able to be at ease and feel relaxed
- n. I looked forward with enjoyment to upcoming events
- o. I felt emotionally stable
- p. I felt lovable
- q. I felt confident
- r. I had a good life
- s. My life was peaceful
- t. I was living life to the fullest
- u. In most ways my life was close to my ideal
- v. I had good control of my thoughts
- w. Even when things were going badly, I still had hope

O13 Please check ALL racial categories with which you identify:

White or Caucasian
 Black or African-American
 Asian
 American Indian or Alaska Native → Enter tribal affiliation:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Middle Eastern or North African
 Native Hawaiian or Other Pacific Islander
 Some other Race, Ethnicity, or Origin:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

O13a If you checked more than one box, is there any one of these which you primarily identify with?

White or Caucasian
 Black or African-American
 Asian
 American Indian or Alaska Native
 Middle Eastern or North African
 Native Hawaiian or Other Pacific Islander
 Some Other Race, Ethnicity, or Origin

O14 How do you currently identify your gender? (Please check only ONE answer)

I am a Female/Woman
 I am a Trans Male/Trans Man
 I am Genderqueer/Gender nonconforming
 I identify in a different way:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

O15 What best describes your romantic or sexual attraction to other people? (Please check only ONE answer)

Heterosexual/Straight
 Lesbian
 Gay
 Bisexual
 Queer
 Questioning
 Something else - please describe:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

E3 How much do you think about your bladder for each of the following types of social activities?

	NOT AT ALL	A LITTLE BIT	SOME	A LOT	ALL THE TIME	MY BLADDER PREVENTS ME FROM DOING THIS
a. Going out to dinner, movies, plays, concerts, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Going out to social events like religious services (church, mosque, temple, etc.), a wedding, or a funeral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Going to home of friends or family for a dinner or party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Having friends or family come to my home for a dinner or party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Spending time with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E4 For each of the following, please indicate the extent to which your bladder currently impacts your daily work, home, or school obligations.

	NONE AT ALL	A LITTLE BIT	SOME	A LOT	ALL THE TIME	MY BLADDER PREVENTS ME FROM DOING THIS
a. Ability to focus your responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Participating in meetings or other group activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting to things on time or keeping to a schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Meeting your responsibilities, such as getting everything done that is expected of you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E5 Overall, with 0 being no impact and 7 being a dramatic negative impact, how much does your bladder affect your ability to meet your day to day obligations?

0	1	2	3	4	5	6	7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO IMPACT							DRAMATIC NEGATIVE IMPACT

E6 Some women find that bladder issues may affect intimacy and their relationships with others, how much does your bladder affect:

	NOT AT ALL	A LITTLE BIT	SOME	A LOT
a. <u>Emotional</u> intimacy with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <u>Physical</u> intimacy, other than sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <u>Sexual</u> intimacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E7 Are you currently

- Single, not seeking to be in a relationship → Answer only **E7a**
- Single, open to or seeking to be in a relationship → Skip to **E7b**
- In a relationship → Skip to **Section F**

E7a How much, if at all, is this due to your bladder? After answering, skip to Section F

- Not at all
- A little
- Some
- A lot
- My bladder is the primary reason I am not in or seeking to be in a relationship → Skip to **Section F**

E7b How much, if at all, is your bladder a consideration in this?

- Not at all
- A little
- Some
- A lot

O9 Thinking about the past year, at the end of the month do you generally: **(Please check only ONE answer)**

- Not have enough money to make ends meet
- Just have enough money to make ends meet
- Have some money left over
- Have more than enough money left over

O10 What is the highest grade or year of school you have completed?

No Schooling Completed

- No schooling completed

Preschool through grade 12

- Nursery/Preschool
- Kindergarten
- Grade 1-12 → Specify highest or current grade: Grade

High School Graduate

- Regular high school diploma
- GED or alternative credential

College or Some College

- Some college credit, but have not completed any degree
- Associate's degree (AA/AS)
- Bachelor's degree (BA/BS)

After Bachelor's Degree

- Master's degree (MA, MS, Meng, Med, MSW, MBA, etc.)
- Professional degree beyond bachelor's degree (MD, DDS, DVM, LLB, JD, etc.)
- Doctorate degree (PhD, EdD, etc.)

O11 What is the primary language you speak at home? **(Please check only ONE answer)**

- English
- Spanish
- Another language:

O12 Do you identify as being of Latino, Hispanic, or Spanish origin? **(Please check ALL answers that apply)**

- No, not of Latino, Hispanic, or Spanish Origin
- Yes, Mexican or Mexican American
- Yes, Puerto Rican
- Yes, Cuban
- Yes, some other Latino, Hispanic, or Spanish Origin:

O5 What best describes your employment status during the past year?
(Please check ALL answers that apply)

a. Homemaker No Yes

b. Student No Yes Part time Yes Full time

c. Retired No Yes

d. Unable to work No Yes

e. Out of work/unemployed No Yes

f. Working one or more jobs No Yes ↴

If yes: Considering all your jobs how many hours a week do you work?

Hours/week

What kind of work do you primarily do? (Name of occupation or description of what you do.)

O6 Do you currently have health insurance?

Yes
 No

O7 Have you ever sought care from a physician or health care provider for bladder problems other than bladder infections?

Yes
 No

O8 Which one of the following categories represents the total household income from all sources last year before taxes?

Less than \$10,000 \$100,000 - \$124,999
 \$10,000 - \$24,999 \$125,000 - \$149,999
 \$25,000 - \$49,999 \$150,000 - \$174,999
 \$50,000 - \$74,999 \$175,000 - \$199,999
 \$75,000 - \$99,999 \$200,000 or more

SECTION F: YOUR BLADDER & MIND

F1 How strongly do you agree or disagree with each of the following: **Due to my bladder:**

	STRONGLY AGREE	AGREE	SOMEWHAT AGREE	SOMEWHAT DISAGREE	DISAGREE	STRONGLY DISAGREE
a. I feel like I am not a healthy person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I enjoy life less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel different from other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I lack confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F2 How strongly do you agree or disagree with each of the following:

	STRONGLY AGREE	AGREE	SOMEWHAT AGREE	SOMEWHAT DISAGREE	DISAGREE	STRONGLY DISAGREE
a. My bladder runs my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My bladder is always on my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F3 The questions below refer to areas in your life which may have been influenced or changed due to problems with your bladder. For each question, check the response that best describes how much your activities, relationships, and feelings are being affected by any bladder issues.

	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
a. Way you dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Emotional health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Does fear of odor restrict your activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Does fear of embarrassment restrict your activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F4 Does your bladder cause you to experience any of the following feelings?

	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
a. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Frustration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Embarrassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Shame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION O: ABOUT YOU

F5 How often do you worry about your bladder, such as worrying about accidental leakage, being able to make it to the bathroom in time, being able to start peeing when you feel the need, etc.?

- Never
- Rarely
- Sometimes
- Usually
- All the time

F6 How much do you think that your bladder contributes to how you feel about your overall health?

- I have never thought about my bladder contributing to my overall health
- Not at all
- Maybe, a little
- Definitely, a little
- Definitely, some
- Definitely, a lot

O1 What is your CURRENT marital status? (Please check only ONE answer)

- Now married
- Widowed
- Divorced
- Separated
- Never married

O2 If you are not married, what is your current primary relationship status? (Please check only ONE answer)

- In a committed relationship, but not living together
- Living with a partner
- Seriously dating someone, but are not in a committed relationship
- Casually dating
- Not dating

O3 Which of the following best describes where you live? (Please check only ONE answer)

- A mobile home
- A one-family house detached from any other house
- A one-family house attached to one or more houses, such as town house or row house
- A building with 2-4 apartments (including duplex, triplex or four plex)
- A building with 5-19 apartments
- A building with 20 or more apartments
- Boat, RV, van, etc.
- Other, please describe:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

O4 Have any of the following happened to you in the past year?

	NO	YES
a. Been homeless	<input type="checkbox"/>	<input type="checkbox"/>
b. Stayed at a shelter, for even one night	<input type="checkbox"/>	<input type="checkbox"/>
c. Been in transitional housing (bridge between homelessness and permanent housing)	<input type="checkbox"/>	<input type="checkbox"/>

SECTION N: SYMPTOM SUMMARY

N1 For any of the things you checked above, why do you think they may have happened? Please check all that apply to you.

- 1 Due to having a Urinary Tract Infection (UTI)
- 2 Due to changes in your routine, such as drinking more than usual
- 3 Due to your menstrual cycle
- 4 Due to being pregnant or having recently given birth
- 5 Due to medications you are taking
- 6 Due to other health issues or problems
- 7 No particular reason

N2 What is your age? years old

SECTION G: RESPONDING TO YOUR BLADDER

G1 During a typical day (waking time), how often do you pee?

times pee waking time

G2 During a typical night (sleeping time), how often do you get up to pee? If you do not get up to pee at least once per night enter 0 (zero).

times pee sleeping time

G3 How often do you use a liner, pad, or absorbent underwear, in case of accidental urine leakage?

- None of the time → Skip to **G4**
- A little of the time
- Some of the time
- Most of the time
- All the time

G3a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

G4 How often is finding out where the bathrooms are one of the first things you do when you go someplace?

- None of the time → Skip to **G5**
- A little of the time
- Some of the time
- Most of the time
- All the time

G4a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

G5 How often do you stay as close to a bathroom as possible when you are away from home?

- None of the time → Skip to **G6**
- A little of the time
- Some of the time
- Most of the time
- All the time

→ **G5a** How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

G6 How often do you make sure you use the bathroom before you leave home?

- None of the time → Skip to **G7**
- A little of the time
- Some of the time
- Most of the time
- All the time

→ **G6a** How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Won't leave home without using the bathroom first

G7 When you plan to leave your home or go out to do things, how much do you cut down on drinking liquids?

- None of the time → Skip to **G8**
- A little of the time
- Some of the time
- Most of the time
- All the time

→ **G7a** How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

M4 Thinking about the last time this happened, did this mostly occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

M5 Thinking about the last time this happened, would you describe it as being...

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

M6 Thinking about the last time any of these things happened when you peed, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

M7 At its worst, how much did this interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

M8 Compared to one year ago, is your trouble starting to pee, or completely emptying your bladder, or dribbling a few drops after you finished peeing better or worse?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION M: YOUR PEE STREAM

M1 Please indicate how often each of the following have happened since you were 11 years old. Please do **NOT** count or consider times when this was a result of having a UTI.

	NEVER	AT LEAST ONCE OR TWICE
a. Trouble or difficulty starting to pee	<input type="checkbox"/>	<input type="checkbox"/>
b. When you pee it flows slowly (just seems to trickle out) or sprays	<input type="checkbox"/>	<input type="checkbox"/>
c. Your urine will start and stop while you are trying to pee	<input type="checkbox"/>	<input type="checkbox"/>
d. Feel like you are not completely emptying your bladder when you have finished peeing (feel like you still need to pee some more, but nothing comes out)	<input type="checkbox"/>	<input type="checkbox"/>
e. Dribbling at least a few drops after you think you have finished peeing	<input type="checkbox"/>	<input type="checkbox"/>

↓
If you answered
NEVER to all items,
skip to **Section N**.

M2 When you experienced any of these things, how long did the longest one last?

- It never lasted for even a full day
- It lasted for at least a full day
- It lasted for several days
- It lasted for longer than that → Answer **M2a**

M2a How much longer?

- It lasted at least a week
- It lasted several weeks
- It lasted for a month or longer
- It was constant

M3 When did this most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

G8 How often do you carry supplies such as: panty liners or pads, extra underwear, etc. with you because of your bladder?

- Never → Skip to **Section H**
- Rarely
- Sometimes
- Usually
- Won't leave home without it

G8a How often do you have to use any of these?

- Daily
- Weekly
- Monthly
- Every month or two
- Every three or four months
- Less often than that

G8b How much does having these things available give you the confidence to do the things you need or want to do?

- Not much at all
- A little
- Some
- A lot
- Extremely

The next set of questions are about things you may have experienced. **Before starting on the questions** please look at each of the following descriptions of bladder related things.

- ♦Urinary tract infections or bladder infections that you had to take antibiotics for
- ♦Had times when you peed more often than usual or expected
- ♦A sudden and urgent need to pee, that "gotta go" feeling that you just had to go
- ♦Discomfort, pain, pressure, or burning in your bladder when peeing
- ♦Trouble starting to pee, or completely emptying your bladder, or dribbling a few drops after you finish peeing

SECTION H: URINARY TRACT INFECTIONS (UTIs)

H1 In the past year have you been told by a health care provider that you had a urinary tract infection (UTI)?

- I have never had a UTI in my life → Skip to **Section I**
- No, I haven't had a UTI in the past year, but I have had at least one in my life → Skip to **H5**
- Yes → Answer **H1a**

H1a How many UTIs have you had in the past year?

- Only one → Skip to **H5**
- Two → Skip to **H5**
- Three
- Four or more

H2 Which of the following best describes your UTIs during the past year? (Choose only one.)

- Constant - more or less the same for the entire year
- Intermittent - sometimes it is better and other times it is worse
- Sporadic - it happens every once in awhile

H3 When you had UTIs, does your bladder got back to your normal or baseline...

- Very Quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

L4 Thinking about the last time this happened, did this mostly occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

L5 Thinking about the last time this happened, which of the following best describes your experience? (Choose only one.)

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

L6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

L7 At its worst, how much did this sensation interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

L8 Compared to one year ago, is this better or worse?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION L: DISCOMFORT, PRESSURE, OR PAIN

The next questions are about some types of sensation in your pelvis or lower abdomen related to peeing or holding urine you may have experienced, such as:

- ♦ A cramping, aching, or stabbing sensation
- ♦ Discomfort or pressure
- ♦ Burning

L1 For each of the following sensations please indicate if you have experienced it with peeing or holding urine since you were 11 years old. Please do NOT count or consider times when this was a result of having a UTI.

		Did you experience this sensation? (Check all that apply)					
		BEFORE YOU PEED		WHILE YOU PEED		AFTER YOU PEED	
a. Cramping, aching, or stabbing	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Discomfort or pressure	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Burning	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**If NO to all of these questions,
Skip to Section M**

L2 How long did the sensation last after you peed? If the sensation went away when you peed, please check N/A.

		How long did this sensation last AFTER you peed?					
		N/A	A FEW MINUTES	LESS THAN AN HOUR	1-4 HOURS	5-12 HOURS	IT NEVER REALLY WENT AWAY
a. Cramping, aching, or stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Discomfort or pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L3 When did this sensation most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

H4 Overall, how much has this interfered with your life in the past year?

- Not at all
- A little bit
- Some
- A lot
- Completely

→ **Skip to Section I**

H5 Have you ever in your life had 3 or more urinary tract infections in a year?

- No → Skip to **Section I**
- Yes → Go to **H6**

H6 During the year when you had at least 3 UTIs, which of the following best describes your experiences with those UTIs? (Check only one.)

- Constant - more or less the same for an extended period of time
- Intermittent - sometimes it is better and other times it is worse
- Sporadic - it happened every once in awhile

H7 When you had UTIs, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It has never seemed to get completely better

H8 Overall, how much did the UTIs interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

SECTION I: HOW OFTEN YOU PEE

I1 Since you were 11 years old, have you ever had times when you peed more often than usual? Please do **NOT** count or consider times when this was a result of having a UTI.

- No, not even once → Skip to **Section J**
- Yes, but it lasted less than a day → Skip to **I2**
- Yes, and it lasted for a full day → Skip to **I2**
- Yes, and it lasted up to several days → Skip to **I2**
- Yes, and it lasted for longer than that → Answer **I1a**

I1a How much longer?

- It lasted at least a week
- It lasted several weeks
- It lasted for a month or longer
- It was constant

I2 When did having to pee more often than usual most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

I3 Thinking about the last time this happened, how much more often than usual did you pee?

- At least four times more often than usual
- Three times more often than usual
- Twice as much as usual
- Less than that

I4 Thinking about the last time this happened, did this feeling of needing to pee more often than usual occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

K6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

K7 At its worst, how much did this accidental urine leakage interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

K8 Compared to one year ago, is your experience with accidentally leaking urine...

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION K: ACCIDENTAL LEAKAGE OF URINE

K1 Since you were 11 years old, have you ever accidentally leaked urine or lost control of pee, even just a drop or two? Please do **NOT** count or consider times when this was a result of having a UTI.

- No, not even once → Skip to **Section L**
- Only once or twice over the entire year
- Yes, once or twice over a month
- Yes, once or twice over a week
- Yes, daily

K2 The last time this accidental urine leakage happened, how much would you say you leaked?

- Just a drop or two
- Medium, more than a few drops but didn't soak through
- Large, soaked through everything

K3 When did this most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

K4 Thinking about the last time this happened, did this occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

K5 Thinking about the last time this happened, which of the following best describes your experiences with accidentally leaking urine? (Choose only one.)

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

I5 Thinking about the last time this happened, which of the following best describes your experiences with peeing more often than usual? (Choose only one.)

- Constant - more or less the same for awhile
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

I6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

I7 At its worst, how much did this need to pee more often than usual interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

I8 Compared to one year ago, is your experience with peeing more often than usual...

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION J: THAT "GOTTA GO" FEELING

J1 Since you were 11 years old, have you ever experienced a sudden and urgent need to pee, that "gotta go" feeling that you just had to go? Please do **NOT** count or consider times when this was a result of having a UTI.

- No, not even once → Skip to **Section K**
- Yes, and it never lasted for even a full day → Skip to **J2**
- Yes, and it lasted for at least a full day → Skip to **J2**
- Yes, and it lasted for several days → Skip to **J2**
- Yes, and it lasted for longer than that → Answer **J1a**

J1a How much longer?

- It lasted at least a week
- It lasted several weeks
- It lasted for a month or longer
- It was constant

J2 When did this "gotta go" feeling most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

J3 When you experience that "gotta go" feeling, which best describes your getting to the bathroom?

- I have no problem holding it until I get to the bathroom
- I worry about whether I can hold it until I get to the bathroom although I always make it
- I can't always hold it until I get to the bathroom
- I usually can't hold it until I get to the bathroom
- I can never hold it until I get to the bathroom

J4 Thinking about the last time this happened, did this occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

J5 Thinking about the last time this happened, which of the following best describes your experiences with the sudden and urgent need to pee? (Choose only one.)

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

J6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

J7 At its worst, how much did this sudden and urgent need to pee interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

J8 Compared to one year ago, is your experience with the sudden and urgent need to pee better or worse?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

Thank you for participating in our study!

We will be asking you questions about your general health and bladder health. Some of our questions will be on sensitive topics, but all of them are important for our research. The findings from this study will help us understand bladder problems and how to prevent them in the future.

- You do not have to answer any questions you don't want to.
- Everything you tell us is confidential and private. (We do not tell anyone your answers, and the information is only used for research).
- There are no right or wrong answers.
- This survey should take approximately 30 minutes to complete.

We will interpret your responding to the questions and mailing the survey back as your agreement to participate in the research.

This study has been reviewed and approved by the University of Minnesota Institutional Review Board regarding research on human subjects. If you have questions about this aspect of the study, please call the Research Subjects' Advocate Line at 612-625-1650.

Participant ID:

Did anyone help you complete this form?

- No
 Yes

We would like to include your responses in a data repository to make data available for use in research after the VIEW study is completed. This repository is maintained by the National Institutes of Health. No identifying information will be sent. If you agree to share your data, you can change your mind up until the end of the VIEW study. When we receive written instructions from you, we will destroy your data and all information that identifies you. After the VIEW study ends, you will not be able to withdraw your data because the Repository will not know which data are yours. Your data will stay in the Repository indefinitely.

Consent to Share Data with the Repository

Please indicate whether you will allow us to share your information with the Repository by putting your initials next to one of the following choices:

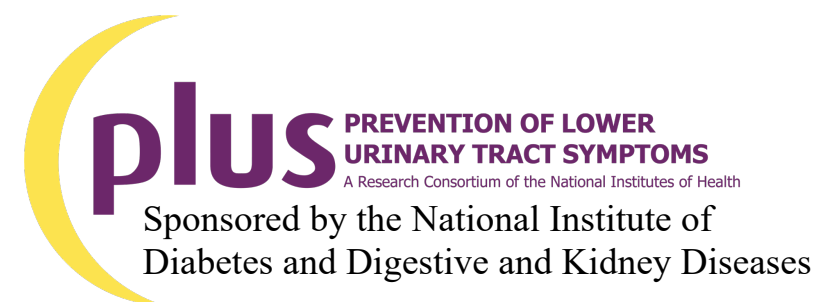
- No, I do not consent to sharing my de-identified information with the Repository
- Yes, I do consent to sharing my de-identified information with the Repository

Participant ID:



Women's Health Survey

Conducted by
Coordinating Centers for Biometric Research
at the University of Minnesota



Did anyone help you complete this form?

- No
- Yes

Participant ID:

Participant ID:

SECTION A: GENERAL HEALTH

SECTION N: SYMPTOM SUMMARY

N1 For any of the things you checked above, why do you think they may have happened? Please check all that apply to you.

- 1 Due to having a Urinary Tract Infection (UTI)
- 2 Due to changes in your routine, such as drinking more than usual
- 3 Due to your menstrual cycle
- 4 Due to being pregnant or having recently given birth
- 5 Due to medications you are taking
- 6 Due to other health issues or problems
- 7 No particular reason

N2 Thinking about the past month, would you say that each of the following has gotten better, worse, or stayed the same?

	MUCH BETTER	SOMEWHAT BETTER	ABOUT THE SAME	SOMEWHAT WORSE	MUCH WORSE
a. Day to day health and function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The function of your bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The health of your bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Your overall health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A1 Overall, how would you rate your well being?

- Excellent
- Very good
- Good
- Fair
- Poor

A2 Taken all together, how would you say things are these days - would you say that your life is very enjoyable, pretty enjoyable, or not too enjoyable?

- Very enjoyable
- Pretty enjoyable
- Not too enjoyable

A3 In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

A4 How is your health, compared with others your age?

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

A5 Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

A6 How often do you wake up feeling refreshed and well rested?

- Almost never
- Rarely
- Sometimes
- Usually
- Almost always

A7 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Have you felt full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A8 How much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A9

NOT AT ALL SLIGHTLY MODERATELY QUITE A BIT EXTREMELY

a. To what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How much did pain interfere with your normal work (including both work outside the home and housework)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

M4 Thinking about the last time this happened, did this mostly occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

M5 Thinking about the last time this happened, would you describe it as being...

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

M6 Thinking about the last time any of these things happened when you peed, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

M7 At its worst, how much did this interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

M8 Compared to one year ago, is your trouble starting to pee, or completely emptying your bladder, or dribbling a few drops after you finished peeing better or worse?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION M: YOUR PEE STREAM

M1 Please indicate how often each of the following have happened since you were 11 years old. Please do **NOT** count or consider times when this was a result of having a UTI.

	NEVER	AT LEAST ONCE OR TWICE
a. Trouble or difficulty starting to pee	<input type="checkbox"/>	<input type="checkbox"/>
b. When you pee it flows slowly (just seems to trickle out) or sprays	<input type="checkbox"/>	<input type="checkbox"/>
c. Your urine will start and stop while you are trying to pee	<input type="checkbox"/>	<input type="checkbox"/>
d. Feel like you are not completely emptying your bladder when you have finished peeing (feel like you still need to pee some more, but nothing comes out)	<input type="checkbox"/>	<input type="checkbox"/>
e. Dribbling at least a few drops after you think you have finished peeing	<input type="checkbox"/>	<input type="checkbox"/>

↓
If you answered
NEVER to all items,
skip to **Section N**.

M2 When you experienced any of these things, how long did the longest one last?

- It never lasted for even a full day
 It lasted for at least a full day
 It lasted for several days
 It lasted for longer than that → Answer **M2a**

M2a How much longer?

- It lasted at least a week
 It lasted several weeks
 It lasted for a month or longer
 It was constant

M3 When did this most recently happen?

- Within the past month
 Within the past few months
 Within the past 6 months
 Within the past year
 Longer than that

A10 How much problem or difficulty do you have doing the following:

	CAN'T DO IT AT ALL				NO PROBLEM AT ALL			
	0	1	2	3	4	5	6	7
a. Vigorous physical activities: ♦Hard physical work such as lifting or carrying heavy objects (over 25 pounds) or exercise such as cross-fit, weightlifting, long distance running, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moderate physical activities: ♦Moderate physical work, such as lifting or carrying things that weigh 5 to 25 pounds (e.g., a heavy bag of groceries, etc.) or exercise such as dancing, jogging, Zumba, aerobics, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Light physical activities: ♦Lifting or carrying things that weigh under 5 pounds or exercise such as stretching, yoga, walking, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A11 Do you have any of these side effects from medications and/or supplements you take?

(If you do not take any medications or supplements, check this box and skip to **Section B**.)

	NO	YES
a. Muscles/movement (stiffness, aches, shaking, feel jittery, etc.).	<input type="checkbox"/>	<input type="checkbox"/>
b. Peeing/urine (such as peeing more or less often, urine color/odor, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Sleep (sleeping a lot, trouble getting to sleep, waking up, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Appetite/weight (gain or loss)	<input type="checkbox"/>	<input type="checkbox"/>
e. Fatigue (feeling tired, hard to concentrate)	<input type="checkbox"/>	<input type="checkbox"/>

When answering the rest of the questions in this survey, please include these side effects even if it is a side effect of a medication or supplement.

SECTION B: GENERAL BLADDER HEALTH & PERFORMANCE

B1 When was the last time you thought about your bladder?

- Hardly ever, I can't remember the last time
- In the past hour
- Within the past few hours
- At least once today
- Within the past week
- At least a month or longer

B2 Which of the following best captures how you feel about your bladder?

- It should be in the Bladder Hall of Fame
- I have a good one
- It works well enough
- It's not great
- I wish I could return it
- I got a lemon/I want a new one

B3 How strongly do you agree with the following statement:

A healthy bladder is a bladder you don't think about.

- Strongly Agree
- Somewhat Agree
- Somewhat Disagree
- Disagree
- Strongly Disagree

B4 My bladder is...

- No bother at all
- A little bothersome
- Somewhat bothersome
- Very bothersome
- A constant bother

L4 Thinking about the last time this happened, did this mostly occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

L5 Thinking about the last time this happened, which of the following best describes your experience? (Choose only one.)

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

L6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

L7 At its worst, how much did this sensation interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

L8 Compared to one year ago, is this better or worse?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION L: DISCOMFORT, PRESSURE, OR PAIN

The next questions are about some types of sensation in your pelvis or lower abdomen related to peeing or holding urine you may have experienced, such as:

- ♦ A cramping, aching, or stabbing sensation
- ♦ Discomfort or pressure
- ♦ Burning

L1 For each of the following sensations please indicate if you have experienced it with peeing or holding urine since you were 11 years old. Please do NOT count or consider times when this was a result of having a UTI.

		Did you experience this sensation? (Check all that apply)					
		BEFORE YOU PEED		WHILE YOU PEED		AFTER YOU PEED	
a. Cramping, aching, or stabbing	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Discomfort or pressure	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Burning	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**If NO to all of these questions,
Skip to Section M**

L2 How long did the sensation last after you peed? If the sensation went away when you peed, please check N/A.

		How long did this sensation last AFTER you peed?					
		N/A	A FEW MINUTES	LESS THAN AN HOUR	1-4 HOURS	5-12 HOURS	IT NEVER REALLY WENT AWAY
a. Cramping, aching, or stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Discomfort or pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L3 When did this sensation most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

B5 How would you rate the function of your bladder?

- Excellent
- Very Good
- Good
- Fair
- Poor
- Terrible

B6 Compared with others your age, is your bladder function...

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

B7 Compared to a year ago, is your bladder function...

- Much better now
- Somewhat better now
- About the same
- Somewhat worse now
- Much worse now

B8 When you laugh, cough, or sneeze do you ever leak even a few drops of urine/pee?

- No, it has never happened
- Yes, but very rarely
- Yes, rarely
- Yes, sometimes
- Yes, often
- Yes, all the time

B9 Usually, I feel like my bladder is the size of...

1	2	3	4	5	6	7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A Pea						A Watermelon

B10 In the past month, how often did you wake up during the night and have trouble getting back to sleep?

- Every night
- Almost always, several nights a week
- Often, at least once a week
- Sometimes, several times a month
- Rarely, less than once a month
- Never → Skip to **B11**

B10a How often is this due to your bladder, such as needing to get up to pee or feeling discomfort?

- Never
- Rarely
- Sometimes
- Often
- Every time

B11 Which best describes your getting to the bathroom in the morning?

- I have no problem holding it until I get to the bathroom
- I worry about whether I can hold it until I get to the bathroom although I always make it
- I can't always hold it until I get to the bathroom
- I usually can't hold it until I get to the bathroom
- I can never hold it until I get to the bathroom

B12 When you feel the need to pee, once you get to the bathroom how well does "getting done what you need to do" happen for you?

- I am just in and out and on with my day
- I take care of things pretty well
- It can be more of a chore than I would like
- I dread when I need to pee

B13 When it comes to my bladder...

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IT CONTROLS ME			IT IS A GIVE AND TAKE RELATIONSHIP				I CONTROL IT			

K6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

K7 At its worst, how much did this accidental urine leakage interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

K8 Compared to one year ago, is your experience with accidentally leaking urine...

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION K: ACCIDENTAL LEAKAGE OF URINE

K1 Since you were 11 years old, have you ever accidentally leaked urine or lost control of pee, even just a drop or two? Please do **NOT** count or consider times when this was a result of having a UTI.

- No, not even once → Skip to **Section L**
- Only once or twice over the entire year
- Yes, once or twice over a month
- Yes, once or twice over a week
- Yes, daily

K2 The last time this accidental urine leakage happened, how much would you say you leaked?

- Just a drop or two
- Medium, more than a few drops but didn't soak through
- Large, soaked through everything

K3 When did this most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

K4 Thinking about the last time this happened, did this occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

K5 Thinking about the last time this happened, which of the following best describes your experiences with accidentally leaking urine? (Choose only one.)

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

SECTION C: YOUR BLADDER AND GENERAL DAY TO DAY

C1 Which of the following best describes you...

I don't think about my bladder, outside of it letting me know that I need to pee → Answer **C1a**

I think about or plan some things around my bladder, such as limiting how much or what I drink, knowing where bathrooms are, always use bathroom before I leave the house, etc. → Skip to **C2**

Somewhere between option 1 and 2 → Skip to **C2**

C1a Has there ever been a time in your life when your bladder interfered with your day to day activities, no matter how minor?

- No, not even once → Skip to **Section E**
- Yes, it has happened at least once or twice recently → Go to **C2**
- Yes, it has happened at least once or twice in the past, but not recently → Skip to **Section D**

C2 How easy or difficult are each of the following?

	VERY EASY	EASY	SOMEWHAT EASY	SOMEWHAT DIFFICULT	DIFFICULT	VERY DIFFICULT
a. When you feel the need to pee, how easy or difficult is it to hold it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. When you feel the need to pee, how easy or difficult is it to start peeing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. When you pee, how easy or difficult is it to completely empty your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C3 How often have you had any of the following problems with your work or other regular daily activities as a result of your bladder?

	NONE OF THE TIME	A LITTLE OF THE TIME	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C4 How much does your bladder impact each of the following, with 0 being no impact and 7 being dramatic negative impact?

	NO IMPACT				DRAMATIC NEGATIVE IMPACT			
	0	1	2	3	4	5	6	7
a. Your ability to enjoy life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How you feel about your overall health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How you feel about yourself as a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Your life in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C5 Thinking about the most recent time your bladder affected you, how long did this last?

- A day or two
- A week
- A month or two
- The past 6 months
- The past year
- Longer than that

C6 Have you ever stopped doing things you enjoy, even if for just a short period of time, because of your bladder?

- No, it never stopped me from doing things I enjoy → Skip to C7
- Yes, I stopped doing one or two things
- Yes, I stopped doing three or four things
- Yes, I stopped doing many things

C6a When was the most recent time you stopped doing something you enjoy because of your bladder?

- Within the past month
- Within the past few months
- Within the past six months
- Longer than that

J5 Thinking about the last time this happened, which of the following best describes your experiences with the sudden and urgent need to pee? (Choose only one.)

- Constant - more or less the same
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

J6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

J7 At its worst, how much did this sudden and urgent need to pee interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

J8 Compared to one year ago, is your experience with the sudden and urgent need to pee better or worse?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION J: THAT "GOTTA GO" FEELING

J1 Since you were 11 years old, have you ever experienced a sudden and urgent need to pee, that "gotta go" feeling that you just had to go? Please do **NOT** count or consider times when this was a result of having a UTI.

- No, not even once → Skip to **Section K**
- Yes, and it never lasted for even a full day → Skip to **J2**
- Yes, and it lasted for at least a full day → Skip to **J2**
- Yes, and it lasted for several days → Skip to **J2**
- Yes, and it lasted for longer than that → Answer **J1a**

J1a How much longer?

- It lasted at least a week
- It lasted several weeks
- It lasted for a month or longer
- It was constant

J2 When did this "gotta go" feeling most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

J3 When you experience that "gotta go" feeling, which best describes your getting to the bathroom?

- I have no problem holding it until I get to the bathroom
- I worry about whether I can hold it until I get to the bathroom although I always make it
- I can't always hold it until I get to the bathroom
- I usually can't hold it until I get to the bathroom
- I can never hold it until I get to the bathroom

J4 Thinking about the last time this happened, did this occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

C7 My bladder is...

- No bother at all
- A little bothersome
- Somewhat bothersome
- Very bothersome
- A constant bother

C8 Have there been times in your life when your bladder interfered with your life more than it does now?

- No, never → Skip to **Section E**
- Yes, but not recently → Answer **C8a**

C8a At its worst, how much did your bladder affect each of the following:

	NOT AT ALL	A LITTLE	SOME	A LOT
a. I accomplished less than I would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I was limited in the kind of work or other activities I could do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I had to cut down on the amount of time I spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

→ Skip to **Section E**

SECTION D: YOUR BLADDER IN THE PAST

D1 While your bladder doesn't currently affect you, you indicated that it has in the past. During the time when your bladder was at its worst, how often did you have any of the following problems with your work or other regular daily activities as a result of your bladder?

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D2 During the time when your bladder affected you the most, how much did your bladder impact each of the following, with 0 being no impact and 7 being dramatic negative impact?

	NO IMPACT				DRAMATIC NEGATIVE IMPACT			
	0	1	2	3	4	5	6	7
a. Your ability to enjoy life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How you feel about your overall health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How you feel about yourself as a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Your life in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D3 Have you ever stopped doing things you enjoy, even if for just a short period of time, because of your bladder?

- No, it never stopped me from doing things I enjoy → Skip to **D4**
- Yes, I stopped doing one or two things
- Yes, I stopped doing three or four things
- Yes, I stopped doing many things

D3a When was the most recent time you stopped doing something you enjoy because of your bladder?

- Within the past 6 months
- Within the past year
- Within the past couple of years
- Longer than that

I5 Thinking about the last time this happened, which of the following best describes your experiences with peeing more often than usual? (Choose only one.)

- Constant - more or less the same for awhile
- Intermittent - sometimes it was better and other times it was worse
- Sporadic - it happens every once in awhile

I6 Thinking about the last time this happened, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

I7 At its worst, how much did this need to pee more often than usual interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

I8 Compared to one year ago, is your experience with peeing more often than usual...

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

SECTION I: HOW OFTEN YOU PEE

I1 Since you were 11 years old, have you ever had times when you peed more often than usual? Please do **NOT** count or consider times when this was a result of having a UTI.

- No, not even once → Skip to **Section J**
- Yes, but it lasted less than a day → Skip to **I2**
- Yes, and it lasted for a full day → Skip to **I2**
- Yes, and it lasted up to several days → Skip to **I2**
- Yes, and it lasted for longer than that → Answer **I1a**

I1a How much longer?

- It lasted at least a week
- It lasted several weeks
- It lasted for a month or longer
- It was constant

I2 When did having to pee more often than usual most recently happen?

- Within the past month
- Within the past few months
- Within the past 6 months
- Within the past year
- Longer than that

I3 Thinking about the last time this happened, how much more often than usual did you pee?

- At least four times more often than usual
- Three times more often than usual
- Twice as much as usual
- Less than that

I4 Thinking about the last time this happened, did this feeling of needing to pee more often than usual occur...

- During day/waking hours
- During night/sleeping hours
- During both the waking and sleeping hours

D4 In the past when your bladder affected you the most, how long did that last?

- A day or two
- A week
- A month or two
- At least 6 months
- At least a year
- Longer than that

D5 At its worst my bladder was...

- No bother at all
- A little bothersome
- Somewhat bothersome
- Very bothersome
- A constant bother

D6 At its worst how much did your bladder affect each of the following:

	NOT AT ALL	A LITTLE	SOME	A LOT
a. I accomplished less than I would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I was limited in the kind of work or other activities I could do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I had to cut down on the amount of time I spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION E: YOUR BLADDER & SPECIFIC ACTIVITIES

E1 Due to your bladder, how much difficulty do you currently have with the following types of physical activity?

CAN'T DO IT AT ALL DUE TO MY BLADDER				NO PROBLEM AT ALL			
0	1	2	3	4	5	6	7

a. Vigorous physical activities that your bladder interferes with:
 ♦Hard physical work such as lifting or carrying heavy objects (over 25 pounds) or exercise such as cross-fit, weightlifting, long distance running, etc.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

b. Moderate physical activities that your bladder interferes with:
 ♦Moderate physical work, such as lifting or carrying things that weight 5 to 25 pounds (e.g., a heavy bag of groceries, etc.) or exercise such as dancing, jogging, Zumba, aerobics, etc.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

c. Light physical activities that your bladder interferes with:
 ♦Lifting or carrying things that weigh under 5 pounds or exercise such as stretching, yoga, walking, etc.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

E2 How much do you think about your bladder with each of the following types of travel?

NOT AT ALL	A LITTLE BIT	SOME	A LOT	ALL THE TIME	MY BLADDER PREVENTS ME FROM DOING THIS	NOT APPLICABLE
------------	--------------	------	-------	--------------	--	----------------

a. Getting around town using your own car (running errands, getting to work, etc.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

b. Getting around town using public transportation (bus, light rail, train) to run errands, get to work, etc.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

c. Long distance traveling in your own car

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

d. Long distance traveling by plane, train, or bus

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

H4 Overall, how much has this interfered with your life in the past year?

- Not at all
- A little bit
- Some
- A lot
- Completely

→ Skip to Section I

H5 Have you ever in your life had 3 or more urinary tract infections in a year?

- No → Skip to Section I
- Yes → Go to H6

H6 During the year when you had at least 3 UTIs, which of the following best describes your experiences with those UTIs? (Check only one.)

- Constant - more or less the same for an extended period of time
- Intermittent - sometimes it is better and other times it is worse
- Sporadic - it happened every once in awhile

H7 When you had UTIs, would you say that your bladder got back to your normal or baseline...

- Very quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It has never seemed to get completely better

H8 Overall, how much did the UTIs interfere with your life?

- Not at all
- A little bit
- Some
- A lot
- Completely

The next set of questions are about things you may have experienced. **Before starting on the questions** please look at each of the following descriptions of bladder related things.

- ◆Urinary tract infections or bladder infections that you had to take antibiotics for
- ◆Had times when you peed more often than usual or expected
- ◆A sudden and urgent need to pee, that "gotta go" feeling that you just had to go
- ◆Discomfort, pain, pressure, or burning in your bladder when peeing
- ◆Trouble starting to pee, or completely emptying your bladder, or dribbling a few drops after you finish peeing

SECTION H: URINARY TRACT INFECTIONS (UTIs)

H1 In the past year have you been told by a health care provider that you had a urinary tract infection (UTI)?

- I have never had a UTI in my life → Skip to **Section I**
- No, I haven't had a UTI in the past year, but I have had at least one in my life → Skip to **H5**
- Yes → Answer **H1a**

H1a How many UTIs have you had in the past year?

- Only one → Skip to **H5**
- Two → Skip to **H5**
- Three
- Four or more

H2 Which of the following best describes your UTIs during the past year? (Choose only one.)

- Constant - more or less the same for the entire year
- Intermittent - sometimes it is better and other times it is worse
- Sporadic - it happens every once in awhile

H3 When you had UTIs, does your bladder got back to your normal or baseline...

- Very Quickly
- Quickly
- Somewhat quickly
- Somewhat slowly
- Slowly
- Very slowly
- It never seems to get completely better

E3 How much do you think about your bladder for each of the following types of social activities?

	NOT AT ALL	A LITTLE BIT	SOME	A LOT	ALL THE TIME	MY BLADDER PREVENTS ME FROM DOING THIS
a. Going out to dinner, movies, plays, concerts, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Going out to social events like religious services (church, mosque, temple, etc.), a wedding, or a funeral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Going to home of friends or family for a dinner or party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Having friends or family come to my home for a dinner or party	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Spending time with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E4 For each of the following, please indicate the extent to which your bladder currently impacts your daily work, home, or school obligations.

	NONE AT ALL	A LITTLE BIT	SOME	A LOT	ALL THE TIME	MY BLADDER PREVENTS ME FROM DOING THIS
a. Ability to focus your responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Participating in meetings or other group activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting to things on time or keeping to a schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Meeting your responsibilities, such as getting everything done that is expected of you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E5 Overall, with 0 being no impact and 7 being a dramatic negative impact, how much does your bladder affect your ability to meet your day to day obligations?

0	1	2	3	4	5	6	7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO IMPACT							DRAMATIC NEGATIVE IMPACT

E6 Some women find that bladder issues may affect intimacy and their relationships with others, how much does your bladder affect:

	NOT AT ALL	A LITTLE BIT	SOME	A LOT
a. <u>Emotional</u> intimacy with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <u>Physical</u> intimacy, other than sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <u>Sexual</u> intimacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E7 Are you currently

- Single, not seeking to be in a relationship → Answer only **E7a**
- Single, open to or seeking to be in a relationship → Skip to **E7b**
- In a relationship → Skip to **Section F**

E7a How much, if at all, is this due to your bladder? After answering, skip to Section F

- Not at all
- A little
- Some
- A lot
- My bladder is the primary reason I am not in or seeking to be in a relationship → Skip to **Section F**

E7b How much, if at all, is your bladder a consideration in this?

- Not at all
- A little
- Some
- A lot

G8 How often do you carry supplies such as: panty liners or pads, extra underwear, etc. with you because of your bladder?

- Never → Skip to **Section H**
- Rarely
- Sometimes
- Usually
- Won't leave home without it

G8a How often do you have to use any of these?

- Daily
- Weekly
- Monthly
- Every month or two
- Every three or four months
- Less often than that

G8b How much does having these things available give you the confidence to do the things you need or want to do?

- Not much at all
- A little
- Some
- A lot
- Extremely

G5 How often do you stay as close to a bathroom as possible when you are away from home?

- None of the time → Skip to **G6**
- A little of the time
- Some of the time
- Most of the time
- All the time

G5a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

G6 How often do you make sure you use the bathroom before you leave home?

- None of the time → Skip to **G7**
- A little of the time
- Some of the time
- Most of the time
- All the time

G6a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Won't leave home without using the bathroom first

G7 When you plan to leave your home or go out to do things, how much do you cut down on drinking liquids?

- None of the time → Skip to **G8**
- A little of the time
- Some of the time
- Most of the time
- All the time

G7a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

SECTION F: YOUR BLADDER & MIND

F1 How strongly do you agree or disagree with each of the following: **Due to my bladder:**

	STRONGLY AGREE	AGREE	SOMEWHAT AGREE	SOMEWHAT DISAGREE	DISAGREE	STRONGLY DISAGREE
a. I feel like I am not a healthy person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I enjoy life less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I feel different from other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I lack confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F2 How strongly do you agree or disagree with each of the following:

	STRONGLY AGREE	AGREE	SOMEWHAT AGREE	SOMEWHAT DISAGREE	DISAGREE	STRONGLY DISAGREE
a. My bladder runs my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. My bladder is always on my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F3 The questions below refer to areas in your life which may have been influenced or changed due to problems with your bladder. For each question, check the response that best describes how much your activities, relationships, and feelings are being affected by any bladder issues.

	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
a. Way you dress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Emotional health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Does fear of odor restrict your activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Does fear of embarrassment restrict your activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F4 Does your bladder cause you to experience any of the following feelings?

	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
a. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Frustration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Embarrassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Shame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION G: RESPONDING TO YOUR BLADDER

F5 How often do you worry about your bladder, such as worrying about accidental leakage, being able to make it to the bathroom in time, being able to start peeing when you feel the need, etc.?

- Never
- Rarely
- Sometimes
- Usually
- All the time

F6 How much do you think that your bladder contributes to how you feel about your overall health?

- I have never thought about my bladder contributing to my overall health
- Not at all
- Maybe, a little
- Definitely, a little
- Definitely, some
- Definitely, a lot

G1 During a typical day (waking time), how often do you pee?

times pee waking time

G2 During a typical night (sleeping time), how often do you get up to pee? If you do not get up to pee at least once per night enter 0 (zero).

times pee sleeping time

G3 How often do you use a liner, pad, or absorbent underwear, in case of accidental urine leakage?

- None of the time → Skip to **G4**
- A little of the time
- Some of the time
- Most of the time
- All the time

G3a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence

G4 How often is finding out where the bathrooms are one of the first things you do when you go someplace?

- None of the time → Skip to **G5**
- A little of the time
- Some of the time
- Most of the time
- All the time

G4a How much confidence does this give you?

- Not much at all
- A little
- Some
- A lot
- Complete confidence



FORM 8: PARTICIPANT EXIT FORM

Participant ID: _____ - _____

Date: ____ / ____ / ____
MM DD YYYY

Reason for participant exit from the study:

- Lost to follow-up
- BHI not completed
- Declined completing consent
- No-show to in-person visit
- Declined to participate at in-person visit
- Did not complete bladder diaries for rescheduled in-person visit
- No longer interested in participating in study
- Bad address
- Participant death
- Quota filled
- Other: _____

Additional Notes: _____



FORM 9: ADVERSE EVENT

Participant ID: _____ - _____

Date: / /
MM DD YYYY

1. Briefly describe the adverse event: _____

2. What was the date of the adverse event? / /
MM DD YYYY

3. Action taken regarding adverse event: _____

4. Was this an expected adverse event or an unexpected adverse event?*

- Expected
- Unexpected

**If unsure, the research center PI will make the determination as to the nature of relatedness*

5. Relationship to research protocol:

- Not related
- Possibly related
- Probably related
- Definitely related

6. Was this a Serious Adverse Event?*

- Yes → Complete Serious Adverse Event Form (next page)
- No

***Serious Adverse Events (SAE) are defined to include any adverse experience resulting in the following:*

- *Persistent or significant disability or incapacity*
- *Hospitalization*
- *Life threatening situation*
- *Death*

Additional Notes: _____

PLUS CONSORTIUM: SERIOUS ADVERSE EVENT NOTIFICATION FORM A-7

SERIOUS ADVERSE EVENT NOTIFICATION FORM (page 1 of 2)	
Participant Number: <input type="text"/> - <input type="text"/>	
1. Did the subject experience a serious adverse event during the course of the study? <input type="checkbox"/> ₁ Yes* <input type="checkbox"/> ₀ No <i>* If Yes, complete remainder of this form</i>	
2. Is this an initial report or a follow-up to an ongoing event? <input type="checkbox"/> ₁ Initial <input type="checkbox"/> ₂ Follow-up, # _____	
3. Subject's age at time of event: <input type="text"/>	
4. Event occurrence: Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Location _____	
EVENT DETAILS	
5. Describe Event:	
6. Actions Taken:	
7. Is the event: <input type="checkbox"/> ₁ Unexpected <input type="checkbox"/> ₀ Expected	
8. Relationship to research protocol: <input type="checkbox"/> ₀ Not related <input type="checkbox"/> ₁ Possibly related <input type="checkbox"/> ₂ Probably related <input type="checkbox"/> ₃ Definitely related	
9. Seriousness of the event:	<input type="checkbox"/> ₁ Death <input type="checkbox"/> ₂ Resulted in a life-threatening illness or injury <input type="checkbox"/> ₃ Resulted in a permanent impairment of a body structure or body function <input type="checkbox"/> ₄ Resulted in a hospitalization or prolongation of an existing hospitalization <input type="checkbox"/> ₅ Required medical or surgical intervention to prevent permanent impairment or damage <input type="checkbox"/> ₆ Congenital anomaly or birth defect in offspring of the subject

PLUS CONSORTIUM: SERIOUS ADVERSE EVENT NOTIFICATION FORM A-7

10. Did the event result in a hospitalization? ₁ Yes ₀ No
If Yes, provide number of in-patient days:

11. Outcome: ₁ Ongoing
If this is a follow-up report, specify: ₁ Improved ₀ Unchanged ₂ Worsened
₂ Resolved
₃ Resolved with sequelae
₄ Death

12. Date of outcome: //
M M D D Y Y Y Y

INVESTIGATOR SIGNATURE

Principal Investigator Name (print) _____

Principal Investigator Signature: _____

Date: //
M M D D Y Y Y Y



FORM 10: PROTOCOL DEVIATION LOG

Participant ID: _____ - _____

Date: ___/___/___
MM DD YYYY

Date of Protocol Deviation: : <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Deviation code: _____ (from list below)
Deviation Code
1. Participant was enrolled but did not meet inclusion criteria
2. Participant was enrolled but met exclusion criteria
3. Participant did not sign Informed Consent
4. Research activities prior to consent
5. De-identification broken
6. Other:
Provide details of deviation (i.e., how deviation occurred, etc.)
Was this protocol deviation reportable to the IRB? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>a. If yes, provide name and signature date of key personnel completing the form</p> <p>Name of key personnel completing form: _____</p> <p>Signature: _____ Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>



2-DAY BLADDER HEALTH SYMPTOM DIARY

PLEASE COMPLETE THIS DIARY FIRST

Participant ID:

DAY 2

Instructions for completing diary

Please complete the 2-Day Bladder Health Symptom Diary BEFORE completing the 1-Day Frequency-Volume Bladder Diary. For two days, we are asking you to record every time you pee or leak urine, as well as your experiences when peeing and after peeing. The two days you record on the 2-Day Symptom Diary should be done on two days in a row.

Choose any 2 days (48-hour period of time) to keep this Diary. You will need to take this Diary with you when you are at home, work or other locations to record your symptoms every time you pee (urinate).

TO COMPLETE THE DIARY:

Begin your Diary with the FIRST time you pee after you wake up from sleep.

Questions 1-8: Complete the questions about your health and your bladder.

At the Start of Each Day: Record the time you get up for the day.

COLUMN 1:

- Every time you pee or if you leak urine (even a drop), please check one of the boxes; P=Peed or L=Leaked. If you both leaked urine and peed, check the box marked "B" for Both.

COLUMN 2:

- Write down the time you peed in this column and check the box for AM or PM.

COLUMN 3:

- If you leaked pee, check if the amount was a small (S), medium (M), or large (L) leakage.

Column 4 – Column 6:

- Check Yes (Y) or No (N) for each question about any bladder urgency, your pee experience, and your after-pee experience.

At the End of Each Day:

- Check Yes (Y) or No (N) if you had an uncomfortable or painful pee sensation or if you experienced pain while holding urine.
- Answer whether this was a typical or normal day for you. If it was not, record why in the box.
- Record the time you go to bed.

EXAMPLE:

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Peed	Time of Pee or Leak	Accidental Leak	Urgency	Pee Experience	After-Pee Experience
 Check Pee or Leak or Both	 Time of Pee or Leak	Amount of Pee Leakage (check one if leak) Small (S) Medium (M) Large (L)	 Had a sudden and urgent need to pee	Easy starting to pee Continuous pee stream	Do you feel bladder is empty? Is the "need to pee feeling" gone? Did you dribble pee when you were done?
<input type="checkbox"/> P <input type="checkbox"/> L <input checked="" type="checkbox"/> B	5 : 35 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input checked="" type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> Y <input type="checkbox"/> N






Column 4	Column 5	Column 6
Urgency	Pee Experience	After-Pee Experience
 A sudden and urgent need to pee, that "gotta go" feeling	Easy starting to pee Continuous pee stream	Do you feel bladder is empty? Is the "need to pee feeling" gone? Did you dribble pee, even a few drops, when you were done?
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N

Did this represent a typical or normal day for you?

- Yes, normal
- No, worse → If no, please state what was different below:
- No, better → If no, please state what was different below:

DAY 2

What time did you get up today? : AM PM

	Column 1	Column 2	Column 3
	Peed	Time of Pee or Leak	Accidental Leak or Lost Control of Pee
	 Check Pee or Leak or Both	 Time of Pee or Leak	Amount of Pee Leakage (check one if leak, even just a drop or two)  Small (S)  Medium (M)  Large (L)
17	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
18	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
19	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
20	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
21	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
22	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
23	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
24	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
25	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
26	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
27	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
28	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
29	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
30	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
31	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L
32	<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L

Pee sensation uncomfortable or painful?
 Yes No

Did you experience pain while you were holding urine?
 Yes No

What time did you go to bed today? : AM PM

Participant ID:

Please complete the following questions.

1. Please enter today's date: / /
M M / D D / Y Y Y Y

2. In general, would you say your health is:
 Excellent
 Very good
 Good
 Fair
 Poor

3. Are you breastfeeding?
 Yes
 No

4. Do you think you have a bladder infection or UTI today?
 Yes
 No

5. Are you pregnant?
 Yes
 No

6. Are you having any respiratory issues (such as a cold or allergies) today?
 Yes
 No

7. Are you catheterized?
 Yes
 No




8. Have you been hospitalized in the past week?
 Yes
 No

Participant ID:

DAY 1

DAY 1

What time did you get up today? : AM PM

Column 1	Column 2		Column 3			Column 4	Column 5		Column 6		
Peed	Time of Pee or Leak		Accidental Leak or Lost Control of Pee			Urgency	Pee Experience		After-Pee Experience		
 Check Pee or Leak or Both	 Time of Pee or Leak		Amount of Pee Leakage (check one if leak, even just a drop or two)			 A sudden and urgent need to pee, that "gotta go" feeling	Easy starting to pee	Continuous pee stream	Do you feel bladder is empty?	Is the "need to pee feeling" gone?	Did you dribble pee, even a few drops, when you were done?
<input type="checkbox"/> P <input type="checkbox"/> L <input type="checkbox"/> B	: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											

Pee sensation uncomfortable or painful?

Yes No

Did you experience pain while you were holding urine?

Yes No

Did this represent a typical or normal day for you?

Yes, normal

No, worse → If no, please state what was different below:

No, better → If no, please state what was different below:

What time did you go to bed today? : AM PM

Participant ID:

Participant ID: