Application 1

**International Consultation on Incontinence. Questionnaire Urinary Incontinence Short Form (ICIQ-SF)**

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| 1. Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Gender \_\_\_\_\_\_\_

***Please, answer to the questions according to situation of the previous month:***3. How often do you observe urinary leak (choose the most appropriate answer)? * Never – 0
* One time per week or rarer – 1
* Two or three times per week – 2
* One time a day – 3
* Several times a day – 4
* All time – 5

4. Indicate the volume of urinary leak (choose the most appropriate answer). * None – 0
* Small volume – 2
* Sufficient volume – 4
* High volume – 6

5. How urinary leak affects your daily life (encircle the required number)? 1 2 3 4 5 6 7 8 9 10*No influence Very strong influence*6. In which situations do you have urine leak (choose the most appropriate answer)?* Never – no urine leak
* While going to bathroom
* When coughing and sneezing
* When sleeping
* During physical load
* Immediately after toilet and putting the clothes on
* Without specific causes
* All time

**Points of ICIQ-SF (3+4+5)** \_\_\_\_\_\_\_\_\_\_\_\_ |