



**QUID: Questionnaire for Urinary Incontinence Diagnosis**



Date of Visit \_\_\_\_\_  
(Month / Day / Year)

**Please complete all questions. Do not leave any questions blank. For each question, mark the box that most accurately describes how often you experience your symptoms.**

Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments...						
	None of the time	Rarely	Once in a while	Often	Most of the time	All of the time
1. When you cough, laugh or sneeze?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. When you bend down or lift something up?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. When you walk quickly, jog, or exercise?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments...						
4. While you are undressing to use the toilet?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5. Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
6. Do you have to rush to the bathroom because you get a sudden, strong need to urinate?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>