Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

FEMALE SEXUAL FUNCTION INDEX (FSFI)

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal (“turn on”) during sexual activity or intercourse?
   - ☐ No sexual activity
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

Name: _____ Date: _____

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very high confidence
- ☐ High confidence
- ☐ Moderate confidence
- ☐ Low confidence
- ☐ Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication (“wetness”) until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm

(climax)?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

- ☐ Did not attempt intercourse

Name: _____ Date: _____

- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

19.Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

SEXUAL DISTRESS SCALE-REVISED

Below is a list of feelings and problems that men and women sometimes have concerning their sexuality. Please read each item carefully, and check the box that best describes how often that problem has bothered you or caused distress **over the last 4 weeks**. Please check only one box for each item, and take care not to skip ANY items.

Please check one box per question.

1. How often did you feel **distressed about your sex life**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

2. How often did you feel **unhappy about your sexual relationship**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

3. How often did you feel **guilty about your sexual difficulties**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

4. How often did you feel **frustrated by your sexual problems**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

5. How often did you feel **stressed about sex**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

6. How often did you feel **inferior because of sexual problems**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

Name: _____ Date: _____

7. How often did you feel **worried about sex**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

8. How often did you feel **sexually inadequate**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

9. How often did you feel **regrets about your sexuality**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

10. How often did you feel **embarrassed about sexual problems**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

11. How often did you feel **dissatisfied with your sex life**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

12. How often did you feel **angry about your sex**?
- ☐ 0 Never
- ☐ 1 Rarely
- ☐ 2 Occasionally
- ☐ 3 Frequently
- ☐ 4 Always

13. How often did you feel **bothered by low desire?**
- c 0 Never
- c 1 Rarely
- c 2 Occasionally
- c 3 Frequently
- c 4 Always

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate *how often* you felt or thought a certain way by checking the box next to it.

1. In the last month, how often have you been upset because of something that happened unexpectedly?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

2. In the last month, how often have you felt that you were unable to control the important things in your life?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

3. In the last month, how often have you felt nervous and "stressed"?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

4. In the last month, how often have you felt confident about your ability to handle your personal problems?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

5. In the last month, how often have you felt that things were going your way?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

6. In the last month, how often have you found that you could not cope with all the things that you had to do?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

7. In the last month, how often have you been able to control irritations in your life?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

Name: _____ Date: _____

8. In the last month, how often have you felt that you were on top of things?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

9. In the last month, how often have you been angered because of things that were outside of your control?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
   - ☐ 0 Never
   - ☐ 1 Almost never
   - ☐ 2 Sometimes
   - ☐ 3 Fairly often
   - ☐ 4 Very often

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

McGILL PAIN QUESTIONNAIRE FOR GENITAL PAIN

Please complete all questions regardless of presence or absence of genital pain.

1. Please check in the appropriate column the degree to which you experienced each type of pain in your genital.

	NONE	MILD	MODERATE	SEVERE
THROBBING	☐ 0	☐ 1	☐ 2	☐ 3
SHOOTING	☐ 0	☐ 1	☐ 2	☐ 3
STABBING	☐ 0	☐ 1	☐ 2	☐ 3
SHARP	☐ 0	☐ 1	☐ 2	☐ 3
CRAMPING	☐ 0	☐ 1	☐ 2	☐ 3
GNAWING	☐ 0	☐ 1	☐ 2	☐ 3
HOT-BURNING	☐ 0	☐ 1	☐ 2	☐ 3
ACHING	☐ 0	☐ 1	☐ 2	☐ 3
HEAVY	☐ 0	☐ 1	☐ 2	☐ 3
TENDER	☐ 0	☐ 1	☐ 2	☐ 3
SPLITTING	☐ 0	☐ 1	☐ 2	☐ 3
TIRING-EXHAUSTING	☐ 0	☐ 1	☐ 2	☐ 3
SICKENING	☐ 0	☐ 1	☐ 2	☐ 3
FEARFUL	☐ 0	☐ 1	☐ 2	☐ 3
PUNISHING-CRUEL	☐ 0	☐ 1	☐ 2	☐ 3

2. Please tick along scale below to rate severity of pain.

NO PAIN ☐----------☐ WORST PAIN

3. Please check in appropriate columns the overall intensity of pain.

PPI

- ☐ 0 NO PAIN
- ☐ 1 MILD
- ☐ 2 DISCOMFORTING
- ☐ 3 DISTRESSING
- ☐ 4 HORRIBLE
- ☐ 5 EXCRUCIATING

Name: _____ Date: _____

PERSONAL HEALTH QUESTIONNAIRE

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and choose your response.

a. Little interest or pleasure in doing things
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

b. Feeling down, depressed or hopeless
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

c. Trouble falling asleep, staying asleep, or sleeping too much
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

d. Feeling tired or having little energy
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

e. Poor appetite or overeating
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you let yourself or your family down
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

g. Trouble concentrating on things such as reading the newspaper or watching television
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

i. Thinking that you would be better off dead or that you want to hurt yourself in some way
- c 0 Not al all
- c 1 Several days
- c 2 More than half the days
- c 3 Nearly every day

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- c 0 Not difficult at all
- c 1 Somewhat difficult
- c 2 Very difficult
- c 3 Extremely difficult

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

HARDER PERSONAL FEELINGS QUESTIONNAIRE (PFQ2)

For each of the following listed feeling, to the left of the item number, please place a number from 0 to 4, reflecting how common the feeling is for you.

4 = Continuously or almost continuously
3 = Frequently but not continuously
2 = Some of the time
1 = Rarely
0 = Never

☐ 1. Embarrassment
☐ 2. Mild guilt
☐ 3. Feeling ridiculous
☐ 4. Worry about hurting or injuring someone
☐ 5. Sadness
☐ 6. Self-consciousness
☐ 7. Feeling humiliated
☐ 8. Intense guilt
☐ 9. Euphoria
☐ 10. Feeling "stupid"
☐ 11. Regret
☐ 12. Feeling "childish"
☐ 13. Mild happiness
☐ 14. Feeling helpless, paralyzed
☐ 15. Depression
☐ 16. Feelings of blushing
☐ 17. Feeling you deserve criticism for what you did
☐ 18. Feeling laughable
☐ 19. Rage
☐ 20. Enjoyment
☐ 21. Feeling disgusting to others
☐ 22. Remorse

Name: _____ Date: _____

Harder, Rockart & Cutler 1993

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SAN DIEGO SEXUAL MEDICINE

VULVAR PAIN FUNCTIONAL QUESTIONNAIRE (V-Q)

These are statements about how pelvic pain can affect your everyday life. **Please check one box for each item below, choosing the one that best describes your situation.** Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment.

1. Because of my pelvic pain
   - ☐ 3 I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.
   - ☐ 2 I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.
   - ☐ 1 I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.
   - ☐ 0 I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain
   - ☐ 3 Gets worse when I walk, so I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
   - ☐ 2 Gets worse when I walk. I can only walk far enough to move around in my house, no further.
   - ☐ 1 Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
   - ☐ 0 My pain does not get worse with walking; I can walk as far as I want to.
   - ☐ 0 I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain
   - ☐ 3 Gets worse when I sit, it hurts too much to sit any longer than 30 minutes at a time.
   - ☐ 2 Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that is it difficult to do my job or sit long enough to watch a movie.
   - ☐ 1 Occasionally gets worse when I sit, but most of the time sitting is comfortable.
   - ☐ 0 My pain does not get worse with sitting; I can sit as long as I want to.
   - ☐ 0 I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills for my pelvic pain
   - ☐ 3 I am sleepy and I have trouble concentrating at work or while I do housework.
   - ☐ 2 I can concentrate to do my work, but I can't do more, like go out in the evenings.
   - ☐ 1 I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
   - ☐ 0 I don't have any problems with the pills that I take for pelvic pain.
   - ☐ 0 I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain
   - ☐ 3 I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
   - ☐ 2 It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
   - ☐ 1 Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
   - ☐ 0 It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain

Name: _____ Date: _____

- ☐ 3 I don't get together with my friends or go out to parties or events.
- ☐ 2 I only get together with my friends or go out to parties or events every now and then.
- ☐ 1 I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
- ☐ 0 I get together with friends or go to events whenever I want, pelvic pain does not get in the way.

7. Because of my pelvic pain
   - ☐ 3 I can't stand for the doctor to insert the speculum when I go to the gynecologist.
   - ☐ 2 I can stand it when the doctor inserts the speculum if they are careful, but most of the time it really hurts.
   - ☐ 1 It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
   - ☐ 0 It never hurts for the doctor to insert the speculum when I go to the gynecologist.

8. Because of my pelvic pain
   - ☐ 3 I cannot use tampons at all, because they make my pain much worse.
   - ☐ 2 I can only use tampons if I put them in very carefully.
   - ☐ 1 It usually doesn't hurt to use tampons, but occasionally it does hurt.
   - ☐ 0 It never hurts to use tampons.
   - ☐ 0 This question doesn't apply to me because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.

9. Because of my pelvic pain
   - ☐ 3 I can't let my partner put a finger or penis in my vagina during sex at all.
   - ☐ 2 My partner can put a finger or penis in my vagina very carefully, but it still hurts.
   - ☐ 1 It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.
   - ☐ 0 It doesn't hurt to have my partner put a finger or penis in my vagina at all.
   - ☐ 0 This question does not apply to me because I don't have a sexual partner.
   - ☐ 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

10. Because of my pelvic pain
    - ☐ 3 It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.
    - ☐ 2 My partner can touch me sexually outside the vagina if we are very careful.
    - ☐ 1 It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt.
    - ☐ 0 It never hurts for my partner to touch me sexually outside the vagina
    - ☐ 0 This question does not apply to me because I don't have a sexual partner.
    - ☐ 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

11. Because of my pelvic pain
    - ☐ 3 It's too painful to touch myself for sexual pleasure.
    - ☐ 2 I can touch myself for sexual pleasure if I am careful.
    - ☐ 1 It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.
    - ☐ 0 It never hurts to touch myself for sexual pleasure.
    - ☐ 0 I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.

Name: _____ Date: _____

SAN DIEGO SEXUAL MEDICINE

PELVIC FLOOR DISTRESS INVENTORY – SHORT FORM 20

Please answer all of the questions in the following survey. These 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. While answering these questions, please consider your symptoms over the **last 3 months.**

The PFDI-20 has 20 items and 3 scales. All items use the following format with a response scale from 0 to 4.

Do you _____ ?

☐ **No** ☐ **Yes** **0**

<u>If yes</u>, how much does it bother you?

☐ 1	☐ 2	☐ 3	☐ 4
Not at all	**Somewhat**	**Moderately**	**Quite a bit**

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6):

☐ 1. Usually experience *pressure* in the lower abdomen?

☐ 2. Usually experience *heaviness* or *dullness* in the pelvic area?

☐ 3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?

☐ 4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?

☐ 5. Usually experience a feeling of incomplete bladder emptying?

☐ 6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?

Name: _____ Date: _____

Colorectal-Anal Distress Inventory 8 (CRADI-8):

☐ 7. Feel you need to strain too hard to have a bowel movement?

☐ 8. Feel you have not completely emptied your bowels at the end of a bowel movement?

☐ 9. Usually lose stool beyond your control if your stool is well formed?

☐ 10. Usually lose stool beyond your control if your stool is loose?

☐ 11. Usually lose gas from the rectum beyond your control?

☐ 12. Usually have pain when you pass your stool?

☐ 13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

☐ 14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

Urinary Distress Inventory 6 (UDI-6):

☐ 15. Usually experience frequent urination?

☐ 16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of need to go to the bathroom?

☐ 17. Usually experience urine leakage related to coughing, sneezing, or laughing?

☐ 18. Usually experience small amounts of urine leakage (that is, drops)?

☐ 19. Usually experience difficult emptying your bladder?

☐ 20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?