Entered: _ _ / _ _ / 20_ _ Initials: _____ Verified: _ _ / _ _ /20 _ _ Initials: _____
mm dd yy mm dd yy

Patient ID __ __ __ - __ __ __ __ - __ __ **Visit: 1**

For office use only.

UIB – Version: 08/28/2006

Form Completion Date __ __ / __ __ / 20 __ __
mm dd yy

Directions: For the following questions, please consider the **past 3 months.**

1. Many people complain that they leak urine accidentally. In the **past 3 months**, how often have you typically leaked urine, even a small amount? (Please record urine loss for any reason and *check one box only*).

   - ☐ 1. Never → *Skip to question 8*
   - ☐ 2. Less than once per month → *Skip to question 8*
   - ☐ 3. Monthly (once or more each month) → *Skip to question 8*
   - ☐ 4. Weekly (once or more each week)
   - ☐ 5. Daily (once or more each day)

2. In the **past 3 months**, how much urine have you typically lost with each episode of urine loss?

   - ☐ 1. Drops
   - ☐ 2. Small splashes (1 to 2 teaspoons)
   - ☐ 3. More

3. In the **past 3 months**, **in a typical week,** how often have you leaked urine, even a small amount:

   a. with a physical activity like coughing, sneezing, lifting or exercise? _____ times per week

   b. with an urge or the feeling that you needed to empty your bladder but you could not get to the toilet fast enough? _____ times per week

   c. for other reasons (**without** any physical activity and **without** a sense of urgency)? _____ times per week

4. In the **past 3 months**, **in a typical week,** have you used supplies (pads or protection) specifically for your urine leakage?

☐ 0. No → *Skip to question 5*

☐ 1. Yes

4.1 How many of each of the supplies listed below have you used **in a typical week specifically for your urine leakage**?

a. Pantyliners or minipads	_____ pads per week
b. Maxipads such as Kotex or Modess	_____ pads per week
c. Incontinence pads such as Serenity or Poise	_____ pads per week
d. Disposable undergarment or protective underwear	_____ undergarments per week

5. In the past 3 months, have you had treatments for urine leakage? □ 0. No □ 1. Yes

If yes, check "no" or "yes" to each:

No	Yes	
□	□	a. Medication
□	□	b. Kegel exercises, biofeedback, bladder training (behavioral therapy)
□	□	c. Changes in fluid intake (decrease fluids, stop caffeine)
□	□	d. Other (Please describe _____)

6. In the **past 3 months,** how much has your urine leakage **affected your day-to-day activities**?

Not at all	Slightly	Moderately	Quite a bit	Extremely
(1)	(2)	(3)	(4)	(5)
□	□	□	□	□

7. In the **past 3 months,** how much has your urine leakage **bothered** you?

Not at all	Slightly	Moderately	Quite a bit	Extremely
(1)	(2)	(3)	(4)	(5)
□	□	□	□	□

8. Have you **ever** had surgery for urine leakage?

□ 0. No □ 1. Yes → When: __ __ __ __ (year)

URINARY INCONTINENCE QUESTIONNAIRE, BASELINE (UIB)

PURPOSE:	To collect urinary incontinence information regarding patients aged 18 years or older enrolled in LABS-1, who have provided informed consent for LABS-2, prior to bariatric surgery, have experienced *during the past week.*
PERSON(S) RESPONSIBLE: **SOURCES OF INFORMATION:**	Clinician/Coordinator Patient
WHEN TO ADMINISTER FORM:	Once patient provides informed consent for LABS-2, prior to surgery. This form should be administered after the GSRS and prior to the BS form. This questionnaire should be completed at the baseline visit only. It can be sent to patient by mail for patient to complete at home and return to coordinator prior to bariatric surgery or it can be completed at the clinic visit. The coordinator or other study staff must review the document at patient's clinic visit to ensure that all fields have been completed appropriately.
GENERAL INSTRUCTIONS (Patient)	This questionnaire is to be completed by the patient. If the patient is not able to complete the form without help, the coordinator or patient designee may read the questions and answers to the patient.
GENERAL INSTRUTIONS: (Clinician)	After patient completes survey: (1) Record whether the survey was completed by the patient alone or completed by the patient with assistance. (2) Review the form for any missing items. Follow-up with patient if necessary to record missing items, or to clarify responses. (3) Make sure that each item has a single response marked, unless directions state otherwise. (4) If the patient does not understand the question, a coordinator or patient designee may read the question to them. Do not answer the question. Indicate whether the response is unknown or if the patient refused to provide an answer.
SCORING ALGORITHM:	**N/A**

DATA SECTION	COMPLETION INSTRUCTIONS
PATIENT ID:	Record the patient's ID number. The ID number is assigned via the ID registration application of the MATRIX Web Data Management System (MATRIX). Instructions on using this application are included in the MATRIX Manual. *NOTE: The patient ID number is the same as that assigned to the patient as part of the LABS-1 study.*
VISIT:	The UIB should be administered at baseline only. The visit number has been pre-printed on the form.
FORM COMPLETION DATE:	Patient records date of form completion (mm/dd/20yy). 1. Patient records the amount of urine leaked accidentally in the *past 3 months.* Patient should record urine loss for any reason and should select only one answer. <u>If patient selects "Never"</u>: Patient may skip to question 8. <u>If patient selects "Less than once per month":</u> Patient may skip to question 8. <u>If patient selects "Monthly":</u> Patient may skip to question 8. 2. Patient records amount of urine lost with each episode in the *past 3 months.* 3. Patient records number of times in *a typical week* that they have leaked urine, even small amounts for each of the listed reasons. 4. Patient selects "No" or "Yes" if they use supplies specifically designed for urine leakage. <u>If patient selects "No":</u> Patient may skip to question 5. 4.1 Patient indicates number of each of the listed supplies that they used *in a typical week* specifically for urine leakage. 5. Patient answers "No" or "Yes" if ever had treatments for urine leakage. If yes, patient specifies "No" or "Yes" for each type of treatment listed in the past 3-months.

DATA SECTION	COMPLETION INSTRUCTIONS
	6. Patient indicates how much urine leakage has affected their daily activities in the *past 3 months*. 7. Patient indicates how much urine leakage has bothered them in the *past 3 months.* 8. Patient indicates "No" or "Yes" if they have *ever* had surgery for urine leakage. <u>If patient selects "No":</u> The have completed the UIB. <u>If patient selects "Yes":</u> Patient must record the year in which they had surgery for urine leakage.