

KINGS HEALTH QUESTIONNAIRE

Patient name: _____ Date of birth: _____

1. How would you describe your health at the present? *(Please tick one answer)*

- Very good
 Good
 Fair
 Poor
 Very poor

2. How much do you think your bladder problem affects your life? *(Please tick 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? *(Tick the box that applies to you)*

3. Role limitations

	1	2	3	4
	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"/> |

4. Physical/Social limitation

	1	2	3	4
	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"/> |

5. Personal relationships

	0	1	2	3	4
	N/A	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"/> |

6. Emotions

	1	2	3	4
	Not at all	Slightly	Moderately	A lot

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 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"/> |

7. Sleep/Energy	1	2	3	4
	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"/>

7. Do you do any of the following?	1	2	3	4
	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"/>

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?	1	2	3
	A little	Moderately	A lot
FREQUENCY: Going to the toilet very often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NOCTURIA: getting up at night to pass urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
URGENCY: a strong and difficult to control desire to pass urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
URGE INCONTINENCE: urinary leakage associated with a strong desire to pass urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STRESS INCONTINENCE: urinary leakage with physical activity eg. coughing, running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NOCTURNAL ENURESIS: wetting the bed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERCOURSE INCONTINENCE: urinary leakage with sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INFECTIONS OF THE URINARY SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLADDER PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>