Interstitial Cystitis (IC) Symptom & Problem Questionnaire

PATIENT NAME ....

Identifying IC

To help your physician to determine if you have IC, please put a check mark next to the most appropriate response to each of the questions shown below. Then add up the numbers to the left of the check marks and write the total at the bottom.

IC Symptom Index

During the past month:

1. How often have you felt the strong need to urinate with little or no warning?

☐ 0 Not at all
☐ 1 Less than 1 time in 5
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

2. Have you had to urinate less than 2 hours after you have finished urinating?

☐ 0 Not at all
☐ 1 Less than 1 time in 5
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

3. How often did you, most typically, get up at night to urinate?

☐ 0 None
☐ 1 Once
☐ 2 Twice
☐ 3 Three times
☐ 4 Four times
☐ 5 Five times or more

4. Have you experienced pain or burning in your bladder?

☐ 0 Not at all
☐ 1 A few times
☐ 2 Fairly often
☐ 3 Usually
☐ 4 Almost always

Add the numerical values of the checked entries:

...... **Total Score**

IC Problem Index

During the past month, how much has each of the following been a problem for you:

1. Frequent urination during the day?

☐ 0 No problem
☐ 1 Very small problem
☐ 2 Small problem
☐ 3 Medium problem
☐ 4 Big problem

2. Getting up at night to urinate?

☐ 0 No problem
☐ 1 Very small problem
☐ 2 Small problem
☐ 3 Medium problem
☐ 4 Big problem

3. Need to urinate with little warning?

☐ 0 No problem
☐ 1 Very small problem
☐ 2 Small problem
☐ 3 Medium problem
☐ 4 Big problem

4. Burning pain, discomfort or pressure in your bladder?

☐ 0 No problem
☐ 1 Very small problem
☐ 2 Small problem
☐ 3 Medium problem
☐ 4 Big problem

Add the numerical values of the checked entries:

...... **Total Score**