Questionnaire
ID number ______________

1. Date administered _____________________________(dd/mm/yy)
2. What was your age at your last birthday? ____________________________(years)
3. What is your date of birth __________/________/_______(dd/mm/yy)
4. Sex (interviewer please tick which applies)
   1. Male
   2. Female
5. What is your union status?
   1. Single
   2. Married
   3. Common law
   4. Divorced
   5. Separated
   6. Visiting
   7. Widowed
   8. Other (please specify) ______________________________

6 A. What is your current living arrangement?
   1. I live alone
   2. I live with my spouse alone
   3. I live with my children alone
   4. I live with a helper alone
   5. I live with my spouse and children
   6. I live with my spouse and helper
   7. I live with my children and helper
   8. I live with my spouse, children and helper
   9. Other (please specify) ______________________________

7. How do you support yourself financially?
   1. I work to support myself only
   2. I receive a pension
   3. Only my children support me
   4. Only my spouse supports me
   5. Both my spouse and children support me
   6. Other (please specify) ______________________________
8. What is your highest level of education?
   1. Below primary education
   2. Primary education
   3. Vocational education
   4. Secondary education
   5. Tertiary education
   6. Other (please specify) ______________________________________

9. How long have you lived at this location?
   1. Less than three months
   2. Greater than three months but less than one year
   3. Greater than one year
   4. Other (please specify) ______________________________________

10. What kind of toilet facilities do you have available to you?
    1. Inside toilet
    2. Outside toilet
    3. Other (please specify) ______________________________________

The following questions are personal and sensitive in nature. We want to gather information about how well you can control your urine flow. Please be as honest in your answers as you can. Your identity will not be linked to your answers. This form only has an identification number on it. Your name will never be associated with this form.

11. In the past one year have you wet yourself with urine or leaked urine accidentally? (Tick which applies)
    1. No _____________________ if no, please skip to question (31)
    2. Yes

12. When did this problem begin (how many years ago)? ________________

13. What time of day do you normally have leakage of urine?
    1. Nighttime only
    2. Daytime only
    3. Mostly nighttime
    4. Mostly daytime
    5. Both night and day
14. How often does it happen? (Tick which best represents)
   1. Once a year
   2. Several times a year
   3. Once a month
   4. More than once a month
   5. Once a week
   6. A few times a week
   7. Once a day
   8. Many times a day

15. How much urine usually comes down each time?
   1. A small amount
   2. More than a small amount but not a lot
   3. A lot

16. Under which condition(s) does urine leakage occur? (Tick all that apply)
   1. Does the leakage come after a strong urge to urinate and you wet yourself before you reach the bathroom? No Yes
   2. Is the leakage caused by sneezing? No Yes
   3. Is the leakage caused by coughing? No Yes
   4. Is the leakage caused by laughing? No Yes
   5. Is the leakage caused by lifting? No Yes
   6. Is the leakage caused by bending? No Yes
   7. Is the leakage caused by hearing running water? No Yes
   8. Other circumstances No Yes (please specify)

________________________________________________________________________
________________________________________________________________________

17. Does urine come down on you before you even feel anything?
   1. No
   2. Yes

18. Do you have to strain to pass urine?
   1. No
   2. Yes

19. Does your urine flow freely?
   1. No
   2. Yes

20. Has urine leakage had any effect on your life?
   1. No
   2. Partially
   3. Yes
21. If yes, can you recall any of the effects it has had on you?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

22. Does urine leakage affect any of the following?
   1. Does it affect your desire to have sex? No □ Yes □
   2. Does it affect your ability to have sex? No □ Yes □
   3. Does it affect your enjoyment of sex? No □ Yes □
   4. Other No □ Yes (please specify) □
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

23. Have you told your doctor about the urine leakage since the problem started?
   1. No □ --------------------------------------------
   2. Yes □ ____________________________ If yes skip to question (27)

24. If no, can you please give the reason(s) why you did not tell your doctor?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

25. Did any of the following reasons affect your decision not to tell your doctor about urine leakage? (Interviewers please tick all that apply)
   Urine leakage does not bother me a lot No □ Yes □
   Urine leakage is normal as people get old No □ Yes □
   Urine leakage has no treatment No □ Yes □
   I did not know which doctor to go to No □ Yes □
   I was ashamed to mention urine leakage to my doctor No □ Yes □
   I cannot afford treatment for urine leakage No □ Yes □

26. Would you have preferred if your doctor asked you about urine leakage?
   1. No
   2. Yes
   3. Would not matter

27. How long after the problem started did you tell your doctor?
28. Were you treated by your doctor?
   1. No  If no please go to question (31)
   2. Yes

29. What kind of treatment did you get? (Please tick all that apply)
   1. Advice
   2. Medications
   3. Surgery
   4. Other (please specify) __________________________________________

30. Did the treatment help?
   1. No
   2. Yes
   3. Somewhat

31. Where do you visit your primary doctor? (Please tick all that apply)
   1. I have no primary doctor
   2. Health center
   3. Hospital
   4. Private Doctor
   5. Other (please specify) __________________________________________

32. Do you have any of the following conditions?
   1. Diabetes? No  Yes
   2. High blood pressure? No  Yes
   3. Prostate problem? No  Yes
   4. Kidney problem? No  Yes
   5. Stroke? No  Yes
   6. Arthritis? No  Yes
   7. Constipation? No  Yes
   8. Problems with walking? No  Yes  if yes please explain
      ________________________________________________________________
      ________________________________________________________________
      ________________________________________________________________
   9. Others No  Yes  (please specify)
      ________________________________________________________________

(Interviewers, questions 33-36 are for Females only)

33. Have you given birth to any children?
   1. No  If no please skip to question 37
   2. Yes
34 A. If you have given birth, how many children have you given birth to?
_______________________________________________

B. (this part of the question is only for those who have urine leakage). Did the urine leakage begin after childbirth? No Yes

35. Did you have any difficult labor?
1. No If no, please go to question 37
2. Yes

36. If yes, please explain
_______________________________________________
_______________________________________________
_______________________________________________

37. Are you taking any medications now?
1. No if no, please go to question (39)
2. Yes

38. If yes, what medications? (Please list)
_______________________________________________
_______________________________________________
_______________________________________________

39. Have you had any surgical operations?
1. No if no please go to question (41)
2. Yes

40. If yes, what operations? (Please list)
_______________________________________________
_______________________________________________

41. Do you have problems where your feces come down on you without your control?
1. No If no please skip the next question
2. Yes

42. If yes, how often does this happen?
1. Sometimes
2. Most of the time
3. All of the time

Thank you very much for your time. We greatly appreciate it.