**Interstitial Cystitis Symptoms Index (ICSI)**

_During the past month:_

_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

_Have you had to urinate less than 2 hours after you 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

_How often did you most typically get up at night to urinate?_

0.__ Not at all  
1.__ Once per night  
2.__ 2 times per night  
3.__ 3 times per night  
4.__ 4 times per night  
5.__ 5 or more times per night

_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 ______

**Interstitial Cystitis Problem Index (ICPI)**

_During the past month:_

_How much has each of the following been a problem for you._

_Frequent urination during the day?_

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

_Getting up at night to urinate?_

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

_Need to urinate with little warning?_

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

_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 ______

**Reference**