Bladder Cancer Index (BCI)

This questionnaire is designed to measure Quality of Life issues in patients with Bladder cancer and/or urinary diversions. In order to help us get the most accurate assessment, it is important that you answer all questions honestly and completely. As with all medical records, **information contained within this survey will remain strictly confidential**.

Name: ________________________________

Hospital Number:________________________

Date of Birth: ___________________________

Today's Date Is:_________________________

Gender: Male Female

Urologist:

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URINARY FUNCTION

This section is about your urinary habits. Please consider **ONLY THE PAST 4 WEEKS**.

1. Which of the following do you currently have?

Own (native) bladder 1
Ileal conduit/ ostomy... 2
Neo-bladder... 3 — 23/
Continent urinary diversion/catheterizable pouch…......... 4
(such as an Indiana, Koch, Miami, Maintz or UCLA pouch)
Other: Specify ________________________................. 5

2. **Over the past 4 weeks**, how often did you typically feel the need to empty your bladder, neo-bladder, pouch or external appliance (bag) during the day?

More frequently than once an hour ………………………. 1
Once an hour ……………………………………………… 2
Once every 2 hours ……………………………………... 3 (Circle one number) — 0/
Once every 3-5 hours ……………………………………… 4
Only once or twice a day ………………………………….. 5

3. **Over the past 4 weeks**, how often have you leaked urine while awake and doing your normal activities?

Every day 1
About once a week... 2 (Circle one number) — 24/
Less than once a week... 3
Not at all.. 4

4. **Over the past 4 weeks**, how often have you leaked urine while sleeping?

Every day 1
About once a week... 2 (Circle one number) — 25/
Less than once a week... 3
Not at all.. 4

5. **Over the past 4 weeks**, which of the following best describes your urinary leakage when you are awake?

No control whatsoever.. 1
Frequent dribbling... 2 (Circle one number) — 26/
Occasional dribbling.. 3
Total control.. 4

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6. **Over the past 4 weeks**, which of the following best describes your urinary leakage when you are sleeping?

No control whatsoever.. 1
Frequent dribbling.. 2 (Circle one number) 27/
Occasional dribbling... 3
Total control... 4

7. How big a problem, if any, has each of the following been for you **during the past 4 weeks**? (Circle one number on each line)

	No Problem	**Very Small Problem**	**Small Problem**	**Moderate Problem**	**Big Problem**	
a. Urine leakage causing skin irritation....................................	0	1	2	3	4	28/
b. Urine leakage causing body odor.........………...................	0	1	2	3	4	29/
c. Blood in the urine	0	1	2	3	4	30/
d. Pain related to urination, stoma or catheterization....................	0	1	2	3	4	31/

8. How big of a bother, if any, has your bladder, stoma, neo-bladder or catheterizable pouch been for you **during the past 4 weeks**?

No bother... 1
Very small bother... 2
Small bother... 3 (Circle one number) 32/
Moderate bother... 4
Big bother... 5

9. **Over the past 4 weeks**, how much have difficulties with your bladder, stoma, neo-bladder or catheterizable pouch limited your activities? (Circle one number on each line)

	Not at all	**A little bit**	**Some what**	**Quite a bit**	**Very much**	
a. Social activities with friends..	0	1	2	3	4	33/
b. Exercise	0	1	2	3	4	34/
c. Sleep	0	1	2	3	4	35/

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BOWEL HABITS

The next section is about your bowel habits and abdominal pain.
Please consider **ONLY THE PAST 4 WEEKS**.

1. How often have you had rectal urgency (felt like I had to pass stool, but did not) **during the past 4 weeks**?

More than once a day.. 1
About once a day.. 2
More than once a week.. 3 (Circle one number) 36/
About once a week.. 4
Rarely or never.. 5

2. How often have you had stools (bowel movements) that were loose or liquid (no form, watery, mushy) **during the past 4 weeks**?

Never.. 1
Rarely.. 2
About half the time.. 3 (Circle one number) 37/
Usually.. 4
Always.. 5

3. How often have your bowel movements been painful **during the past 4 weeks**?

Never.. 1
Rarely.. 2
About half the time.. 3 (Circle one number) 38/
Usually.. 4
Always.. 5

4. How many bowel movements have you had on a typical day **during the past 4 weeks**?

One or less.. 1
Two 2
Three.. 3 (Circle one number) 39/
Four or more.. 4

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5. How big a problem, if any, has each of the following been for you **during the past 4 weeks**?
(Circle one number on each line)

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem	
a. Urgency to have a bowel movement	0	1	2	3	4	40/
b. Increased frequency of bowel movements............................	0	1	2	3	4	41/
c. Bloody stools	0	1	2	3	4	42/
d. Rectal/ Abdominal/ Pelvic pain………	0	1	2	3	4	43/
e. Constipation ....……….	0	1	2	3	4	44/

6. Overall, how big a problem have your bowel habits been for you **during the past 4 weeks**?

Big problem.. 1
Moderate problem 2
Small problem.. 3 (Circle one number) 45/
Very small problem.. 4
No problem.. 5

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SEXUAL FUNCTION

The next section is about your sexual function and sexual satisfaction. Many of the questions are very personal, but they will help us understand the important issues that you face every day. Remember, THIS SURVEY INFORMATION IS COMPLETELY **CONFIDENTIAL**. Please answer honestly about **THE PAST 4 WEEKS ONLY**.

1. How would you rate each of the following **during the past 4 weeks**? (Circle one number on each line)

	Very Poor	Poor	Fair	Good	Very Good	
a. Your level of sexual desire?	1	2	3	4	5	46/
b. Your ability to reach orgasm (climax)?	1	2	3	4	5	47/
c. Your level of sensation in the genital area?	1	2	3	4	5	48/
d. Your ability to be sexually aroused?	1	2	3	4	5	49/
e. Your ability to have intercourse?	1	2	3	4	5	50/

2. **Over the past 4 weeks**, how often did you have <u>any</u> sexual activity?

Not at all.. 1
Less than once a week.. 2
About once a week.. 3 (Circle one number) 51/
More than once a week.. 4

3. **Over the past 4 weeks**, how often have you had pain related to intercourse?

Never.. 1
Seldom.. 2
Not often.. 3 (Circle one number) 52/
Often.. 4
Very often.. 5

4. How big a problem, if any, has each of the following been for you **during the past 4 weeks**? (Circle one number on each line)

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem	
a. Your level of sexual desire	0	1	2	3	4	53/
b. Your ability to have intercourse	0	1	2	3	4	54/
c. Your ability to reach orgasm	0	1	2	3	4	55/

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5. Overall, how would you rate your ability to function sexually **during the past 4 weeks**?

Very poor.. 1
Poor... 2
Fair.. 3 (Circle one number) 56/
Good.. 4
Very good... 5

6. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the past 4 weeks**?

No problem... 1
Very small problem.. 2
Small problem.. 3 (Circle one number) 57/
Moderate problem.. 4
Big problem.. 5

THANK YOU VERY MUCH!!!