

Supplementary Material. Douleur Neuropathique 4 Questions (DN4) questionnaire

Please complete this questionnaire by ticking one answer for each item in the 4 questions below.

Interview of the patient

Question 1: Does the pain have one or more of the following characteristics?

- | | | |
|--------------------|---------------------------|--------------------------|
| 1. Burning | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Painful cold | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Electric shocks | <input type="radio"/> Yes | <input type="radio"/> No |

Question 2: Is the pain associated with one or more of the following symptoms in the same area?

- | | | |
|---------------------|---------------------------|--------------------------|
| 4. Tingling | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Pins and needles | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Numbness | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Itching | <input type="radio"/> Yes | <input type="radio"/> No |

Examination of the patient

Question 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

- | | | |
|--------------------------|---------------------------|--------------------------|
| 8. Hypoesthesia to touch | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Hypoesthesia to prick | <input type="radio"/> Yes | <input type="radio"/> No |

Question 4: In the painful area, can the pain be caused or increased by:

- | | | |
|----------------|---------------------------|--------------------------|
| 10. Brushing ? | <input type="radio"/> Yes | <input type="radio"/> No |
|----------------|---------------------------|--------------------------|

To collate:

- Score 1 to each YES answer
- Score 0 to each NO answer
- If the score is 4 or higher then the pain is likely to be neuropathic pain.
- If the score is less than 4 then the pain is unlikely to be neuropathic pain.

OAB Questionnaire

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms. Please circle the number that best describes how much you have been bothered by each symptom. Add the numbers together for a total score and write that in the box below the chart.

During the past 4 weeks, how bothered were you by:	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. Frequent urination during daytime hours?	0	1	2	3	4	5
2. An uncomfortable urge to urinate?	0	1	2	3	4	5
3. A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
4. Accidental loss of small amounts of urine?	0	1	2	3	4	5
5. Night-time urination?	0	1	2	3	4	5
6. Waking up at night because you had to urinate?	0	1	2	3	4	5
7. An uncontrollable urge to urinate?	0	1	2	3	4	5
8. Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5
Are you a male? If male, add 2 points to your score						

Add up your score: _____

If your score is 8 or greater, you may have overactive bladder. There are effective treatments for this condition. You may want to talk to a healthcare professional about your symptoms.