Urinary Symptom Score

Patient Name _____ Date _____

(Circle the number that best applies to you for each question)

	Not at all	**Less than 1 in 5**	**Less than ½ the time**	**About ½ the time**	**More than ½ the time**	**Almost Always**
1.) Over the last month or so, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2.) During the last month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3.) During the last month or so, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4.) During the last month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5.) During the last month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6.) During the last month or so, how often have you had to push to begin urination?	0	1	2	3	4	5
7.) During the last month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add up all the numbers circled above and write the total in the space to the right.
SYMPTOM SCORE= 1-7 Mild 8-19 Moderate 20-35 Severe **YOUR TOTAL _____**

Quality of Life

	Delighted	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6