

Name: _____

Date: _____

NATUROPATHIC FAMILY CARE AND ISSELS MEDICAL CENTER

American Urological Association Symptom Questionnaire

Directions: Please circle one score for each symptom described within the past month.

URINARY PROBLEMS

	Not at all	Less than 1 in 5	Less than half	Half the time	More than half	Almost always
1. Incomplete Emptying Over the past month, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5+ times
7. Nocturia Over the past month, 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

QUALITY OF LIFE DUE TO URINARY PROBLEMS

	Delighted	Pleased	Mostly Satisfied	Mixed/ Equal	Mostly Dis-Satisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

If this is a follow-up visit for a urological concern, do you feel your symptoms have overall: (circle one)

IMPROVED

WORSENERD

STAYED THE SAME

Source: McConnell JD: *Benign Prostatic Hyperplasia; Diagnosis and Treatment*. Clinical Practice Guideline No.8. AHCPR Publication No. 94-0582.

Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services, 1994.

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

- | | Yes | No |
|--|---------------------------------------|---------------------------------------|
| a. Area between rectum and testicles (perineum) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| b. Testicles | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| c. Tip of the penis (not related to urination) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| d. Below your waist, in your pubic or bladder area | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

2. In the last week, have you experienced:

- | | Yes | No |
|--|---------------------------------------|---------------------------------------|
| a. Pain or burning during urination? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| b. Pain or discomfort during or after sexual climax (ejaculation)? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

3. How often have you had pain or discomfort in any of these areas over the last week?

- ₀ Never
- ₁ Rarely
- ₂ Sometimes
- ₃ Often
- ₄ Usually
- ₅ Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

- | | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| NO PAIN | | | | | PAIN AS BAD AS YOU CAN IMAGINE | | | | | |

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- 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

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- 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

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ₀ None
- ₁ Only a little
- ₂ Some
- ₃ A lot

8. How much did you think about your symptoms, over the last week?

- ₀ None
- ₁ Only a little
- ₂ Some
- ₃ A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ₀ Delighted
- ₁ Pleased
- ₂ Mostly satisfied
- ₃ Mixed (about equally satisfied and dissatisfied)
- ₄ Mostly dissatisfied
- ₅ Unhappy
- ₆ Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3, and 4 = _____

Urinary Symptoms: Total of items 5 and 6 = _____

Quality of Life Impact: Total of items 7, 8, and 9 = _____