

Patient Name: _____
Today's Date: _____

DOB: _____

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

Incomplete
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating? 0 1 2 3 4 5

Frequency
Over the past month, how often have you had to urinate again less than two hours after you finished urinating? 0 1 2 3 4 5

Intermittency
Over the past month, how often have you found you stopped and started again several times when you urinated? 0 1 2 3 4 5

Urgency
Over the past month, how often have you found it difficult to postpone urination. 0 1 2 3 4 5

Weak stream
Over the past month, how often have you had a weak urinary stream? 0 1 2 3 4 5

Straining
Over the past month, how have you had to push or strain to begin urination? 0 1 2 3 4 5

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 symptoms
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=delighted 1=pleased 2=mostly satisfied 3=mixed 4=mostly dissatisfied
5=unhappy 6=terrible

FEMALE REPRODUCTION/URINARY

Date of last period _____

Yes No

_____ _____ Postmenopausal
_____ _____ If you are postmenopausal or post hysterectomy, do you still
_____ _____ bleed vaginally?
_____ _____ Satisfied with your current sex life
_____ _____ Pain or bruising with urination