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PATIENT SELF-ASSESSMENT
BPH* SYMPTOM SCORE†

Name:

Date:

| | Not at all | Less than 1 in 5 times | Less than half the time | About half | More than half the time | Almost always | |
|---|------------|------------------------|-------------------------|------------|-------------------------|-----------------|--------------------------|
| <i>Incomplete emptying</i> | | | | | | | |
| Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> |
| <i>Frequency</i> | | | | | | | |
| 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 | <input type="checkbox"/> |
| <i>Intermittency</i> | | | | | | | |
| 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 | <input type="checkbox"/> |
| <i>Urgency</i> | | | | | | | |
| Over the past month, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> |
| <i>Weak Stream</i> | | | | | | | |
| Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> |
| <i>Straining</i> | | | | | | | |
| Over the past month, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 | <input type="checkbox"/> |
| <i>Notcuria</i> | | | | | | | |
| 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? | None | 1 time | 2 times | 3 times | 4 times | 5 times or more | <input type="checkbox"/> |

TOTAL SYMPTOM SCORE

Total score: 0-7 mildly symptomatic 8-19 Moderately symptomatic 20-35 Severely symptomatic

Bother Score

| | Delighted | Pleased | Mostly satisfied | Mixed (about equally dissatisfied and satisfied) | Mostly dissatisfied | 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 | <input type="checkbox"/> |