

Please answer the following questions about your urinary symptoms. Write your score for each question at the end of each row. The results from this questionnaire will help your doctor to assess if you have an enlarged prostate.

1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 5 |

2. How often have you had to urinate again less than two hours after you finished urinating?

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 5 |

3. How often have you stopped and started again several times when you urinated?

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 5 |

4. How often have you found it difficult to postpone urination?

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 5 |

5. How often have you had a weak urinary stream?

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 5 |

6. How often have you had to push or strain to begin urination?

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 5 |

7. 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.

- |                         |                          |   |
|-------------------------|--------------------------|---|
| Never                   | <input type="checkbox"/> | 0 |
| Less than 1 time in 5   | <input type="checkbox"/> | 1 |
| Less than half the time | <input type="checkbox"/> | 2 |
| About half the time     | <input type="checkbox"/> | 3 |
| More than half the time | <input type="checkbox"/> | 4 |
| Almost always           | <input type="checkbox"/> | 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?

- |                  |                          |   |
|------------------|--------------------------|---|
| Excellent        | <input type="checkbox"/> | 0 |
| Satisfied        | <input type="checkbox"/> | 1 |
| Mostly satisfied | <input type="checkbox"/> | 2 |
| Mixed            | <input type="checkbox"/> | 3 |
| Unhappy          | <input type="checkbox"/> | 4 |
| Terrible         | <input type="checkbox"/> | 5 |

Calculate Results

Total IPSS-Score S:

Quality of Life Index L:

The results from this questionnaire will help your doctor to assess if you have an enlarged prostate. This is a common and benign (non-cancerous) condition that often occurs in older men. (The results do not help to diagnose prostate cancer.) In general, a score of:

**0-7** indicates mild symptoms · **8-19** indicates moderate symptoms · **20-35** indicates severe symptoms

See your doctor to discuss the results if your score indicates moderate or severe symptoms.