

Name: _____ Date: _____

Use the 0-5 scale to best answer the following questions.

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

- 1. INCOMPLETE EMPTYING
 Over the last month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating? 0 1 2 3 4 5
- 2. FREQUENCY
 During the last month or so, how often have you had to urinate again less than 2 hours after you finished urinating? 0 1 2 3 4 5
- 3. INTERMITTENCY
 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. URGENCY
 During the last month or so, how often have you found it difficult to postpone urination? 0 1 2 3 4 5
- 5. WEAK STREAM
 During the last month or so, how often have you had a weak urinary stream? 0 1 2 3 4 5
- 6. STRAINING
 During the last month or so, how often have you had to push or strain to begin urination? 0 1 2 3 4 5
- 7. SLEEPING
 During the last 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
 (times at night)

Specific Quality of Life Question (bother score) scored on a scale from 0 to 6 points (delighted to 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?

Delighted	Pleased	Mostly satisfied	Mixed	Mostly disappointed	Unhappy	Terrible
0	1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		