atlantic urological associates
a professional service corporation

Check the Facts

ABOUT YOUR URINARY ACTIVITIES

NAME AGE

Circle your score for each below.

	None	1 time	2 times	3 times	4 times	5 or more times
1 Over the last month or so, 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

	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
2 Over the past 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
3 Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
4 Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
5 Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
6 Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
7 Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

From the American Urological Association (AUA) Symptom Index for BPH.

Total Symptom Score = Sum of Questions 1 to 7 = ☐

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe

Quality of Life How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6