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AMERICAN UROLOGICAL ASSOCIATION (AUA) SYMPTOM SCORE

NAME: ______________________________ **DATE OF BIRTH:** ____________________

Patient Instructions: Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select **ONLY ONE** response for each question.

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

Never	Almost Never	A Few Times (Less than half the time)	Sometimes (Half the time)	Most Times (More than half the time)	Almost Always
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

2. Over the past month, how often have you had to urinate again less than two hours after you finished urinating?

Never	Almost Never	A Few Times (Less than half the time)	Sometimes (Half the time)	Most Times (More than half the time)	Almost Always
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

3. Over the past month, how often have you found that you stopped and started again several times when you urinated?

Never	Almost Never	A Few Times (Less than half the time)	Sometimes (Half the time)	Most Times (More than half the time)	Almost Always
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

4. Over the past month, how often have you found it difficult to postpone urination?

Never	Almost Never	A Few Times (Less than half the time)	Sometimes (Half the time)	Most Times (More than half the time)	Almost Always
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

5. Over the past month, how often have you had a weak stream?

Never	Almost Never	A Few Times (Less than half the time)	Sometimes (Half the time)	Most Times (More than half the time)	Almost Always
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

6. Over the past month, how often have you had to push or strain to begin urination?

Never	Almost Never	A Few Times (Less than half the time)	Sometimes (Half the time)	Most Times (More than half the time)	Almost Always
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

7. Over the past month or so, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

Never	Once	Twice	Three Times	Four Times	Five or More
0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

Please add the score of the seven questions above for your total out of 35 possible: ____ / 35

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?

○ Delighted ○ Pleased ○ Mostly satisfied ○ Mixed ○ Mostly dissatisfied ○ Unhappy ○ Terrible

Please fill out the form, print it and bring it with you to your appointment.

(Due to privacy concerns, the form cannot be e-mailed)