Patient Questionnaire: International Prostate Symptom Score (IPSS)

Determine Your BPH Symptoms Circle your answers and add up your scores at the bottom.

Over the past months, have you had:	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often do you find it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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
Add Your Symptom Scores: (from each column)	+	+	+	+	+	

Total Score _____

0 – 7 mild symptoms
8 – 19 moderate symptoms
20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed: Equally satisfied/ dissatisfied	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Urinary Symptoms Survey

Date		Age	
Name		Phone #	
Doctor		Primary Care Doctor	

Which symptoms best describe you?	
☐ Frequent urination – Day, Night, Both	☐ Feeling my bladder is not completely empty
☐ Pain during urination	☐ Urge to urinate soon after urinating
☐ Difficulty starting a stream/weak flow	☐ Dribbling after urination
How long have you had these symptoms?	

Have you tried medications to help your symptoms?			☐ YES ☐ NO (CHECK ONE)	
☐ Flomax® (tamsulosin)	☐ Rapaflo® (silodosin)	☐ Uroxatral® (alfuzosin)	☐ Avodart® (dutasteride)	☐ Jalyn® (dutasteride and tamsulosin)
☐ Hytrin® (terazosin)	☐ Cialis® (tadalafil)	☐ Proscar® (finasteride)	☐ Saw Palmetto	☐ Other:

Did these medications help your symptoms? (check one box)									
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

No Relief *Completely Cured*

If you've stopped taking your medications, tell us why:			
☐ Did not help	☐ Side effects	☐ Too expensive	☐ Other

Describe Side Effects:	
Behavior Modifications Tried:	

What is your level of frustration with your urinary symptoms? (check one box)									
☐ 10	☐ 9	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Very Frustrated *Not Frustrated*

Do you currently have any problems with sexual function?		
☐ Erectile Dysfunction	☐ Ejaculatory Dysfunction	☐ Other:

I am interested in learning more about treatment alternatives to medication.	☐ YES ☐ NO (CHECK ONE)