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PATIENT SELF-ASSESSMENT
BPH* SYMPTOM SCORE†

Name:

Date:

	Not at all	Less than 1 in 5 times	Less than half the time	About half	More than half the time	Almost always	
<i>Incomplete emptying</i>							
Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5	<input type="checkbox"/>
<i>Frequency</i>							
Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	<input type="checkbox"/>
<i>Intermittency</i>							
Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	<input type="checkbox"/>
<i>Urgency</i>							
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	<input type="checkbox"/>
<i>Weak Stream</i>							
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	<input type="checkbox"/>
<i>Straining</i>							
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	<input type="checkbox"/>
<i>Notcuria</i>							
Over the past 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?	None	1 time	2 times	3 times	4 times	5 times or more	<input type="checkbox"/>

TOTAL SYMPTOM SCORE

Total score: 0-7 mildly symptomatic 8-19 Moderately symptomatic 20-35 Severely symptomatic

Bother Score

	Delighted	Pleased	Mostly satisfied	Mixed (about equally dissatisfied and satisfied)	Mostly dissatisfied	unhappy	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?	0	1	2	3	4	5	6	<input type="checkbox"/>