

# Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for you doctor to assess your score. Please do not mark anything in these columns.

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? YES _____ NO _____							
4a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse	Never	Occasionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, uretha, perineum, testes, scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain, is it usually...		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually...		Mild	Moderate	Severe			
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
<b>Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a)- SUBTOTAL</b>							
<b>Bother Score (2b, 4b, 7b, 8b)- SUBTOTAL</b>							
<b>TOTAL SCORE (symptom Score + Bother Score) =</b>							