Urinary Symptom Screener (AUA Symptom Score)

*****For Office Use Only*****
Prior Balance: $___________
Due Today: $_____________
Total Due: $_____________
Payment By: Cash, Credit, Check#_______
Amount Paid: $________

Patient Name:_______________________________________ **Date**___/___/___

Circle the number that best describes your experience.	Not at all	Less than 1 time in 5	Less than 1/2 the time	About 1/2 the time	More than 1/2 the time	Almost Always
1.Incomplete Emptying Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
2. Frequency Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3.Intermittency 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
4.Urgency Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5.Weak Stream Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6.Straining Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7.Nocturia Over the past month or so, how many times did you typically get up to urinate from the time you went to bed to the time you got up in the morning?	0	1	2	3	4	5

Add the score for each question above, and write the total in the space to the right.

Symptom score=1-7 Mild 8-19 Moderate 20-35 Severe **TOTAL**_________________

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	Most Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	1	2	3	4	5	6

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O'Leary-Sant Interstitial Cystitis Symptom and Problem Questionnaire

Symptom Index	Problem Index
1.In the past month, How often have you felt the strong need to urinate with little or no warning? 0___not at all 1___less than 1 time in 5 2___less than half the time 3___about half the time 4___more than half the time 5___almost always 2.During the past month, have you had to urinate less than 2 hours after you finished urinating? 0___not at all 1___less than 1 time in 5 2___less than half the time 3___about half the time 4___more than half the time 5___almost always 3.During the past month, how often did you most typically get up at night to urinate? 0___none 1___once 2___2 times 3___3 times 4___4 times 5___5 or more time 4.During the past month, have you experienced pain or burning in you bladder? 0___not at all 1___a few times 2___almost always 3___fairly often 4___usually Total Score:_______ (add all questions in the column) IC>,=6, controls <6	During the past month, how much has each of the following been a problem for you? 1.Frequent Urination during the day? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem 2.Getting up at night to urinate? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem 3.Need to urinate with little warning? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem 4.burning, pain, discomfort, or pressure in your bladder? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem Total Score:______ (add all questions in the column) IC>,=6,controls<6