

**MALE ONLY****PLEASE FILL OUT COMPLETELY**

AUA Symptom Score: Circle one number on each line							
Questions to be answered	Not at all	Less than 1 time in 5	less than half the time	About half the time	More than half the time	Almost always	
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5	
<b>Quality of Life due to Urinary Symptoms</b> 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?	<i>Delighted</i>	<i>Pleased</i>	<i>Mostly Satisfied</i>	<i>Mixed</i>	<i>Mostly Dissatisfied</i>	<i>Unhappy</i>	<i>Terrible</i>
	0	1	2	3	4	5	6
Sum of <b>seven circled numbers</b> (AUA Symptom Score): _____ <b>Scoring:</b> Mild: 0 to 7 Moderate: 8 to 19 Severe: 20 to 35							