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 your doctor to assess your score. Please do not mark anything in these columns. Be sure to bring this questionnaire with you into the examination room so that you can review your answers with your doctor.

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+		
2	**a.** How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. 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** ____							
4	**a. 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			
	b. 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, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6	Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	**a.** If you have pain, is it usually...		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8	**a.** If you have urgency, is it usually...		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
					SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) — SUBTOTAL			
					BOTHER SCORE (2b, 4b, 7b, 8b) — SUBTOTAL			
					TOTAL SCORE (Symptom Score + Bother Score) =			

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