

International prostate symptom score (I-PSS)

Patient Name: _____ Date of Birth: _____ Date Completed: _____

In the Past Month:	Not at all	Less than 1 in 5 times	Less than Half the time	About Half the time	More than Half the time	Almost always	Your score
1. Incomplete emptying Over the past month, 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, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency 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	
4. Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
5. Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	Your score
7. Nocturia Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	
Total IPSS score							

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic 8-19 moderately symptomatic 20-35 severely symptomatic.

1. Over the **past 4 weeks**, how often have you leaked urine?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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2. Which of the following best describes your urinary control **during the last 4 weeks**?

- No urinary control whatsoever..... 1
- Frequent dribbling..... 2 (Circle one number)
- Occasional dribbling..... 3
- Total control..... 4

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3. How many pads or adult diapers per day did you usually use to control leakage **during the last 4 weeks**?

- None 0
- 1 pad per day..... 1
- 2 pads per day..... 2 (Circle one number)
- 3 or more pads per day..... 3

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4. How big a problem, if any, has each of the following been for you **during the last 4 weeks**?

(Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Dripping or leaking urine	0	1	2	3	4	28/
b. Pain or burning on urination.....	0	1	2	3	4	29/
c. Bleeding with urination.....	0	1	2	3	4	30/
d. Weak urine stream or incomplete emptying.....	0	1	2	3	4	31/
e. Need to urinate frequently during the day.....	0	1	2	3	4	33/

5. Overall, how big a problem has your urinary function been for you **during the last 4 weeks**?

- No problem..... 1
- Very small problem..... 2
- Small problem..... 3 (Circle one number)
- Moderate problem..... 4
- Big problem..... 5

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6. How big a problem, if any, has each of the following been for you? (Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Urgency to have a bowel movement	0	1	2	3	4	49/
b. Increased frequency of bowel movements.....	0	1	2	3	4	50/
c. Losing control of your stools.....	0	1	2	3	4	52/
d. Bloody stools	0	1	2	3	4	53/
e. Abdominal/ Pelvic/Rectal pain...	0	1	2	3	4	54/

7. Overall, how big a problem have your bowel habits been for you **during the last 4 weeks?**

No problem.....	1					
Very small problem.....	2					
Small problem.....	3					(Circle one number)
Moderate problem.....	4					
Big problem.....	5					55/

8. How would you rate each of the following **during the last 4 weeks?** (Circle one number on each line)

	<u>Very Poor to None</u>	<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>Very Good</u>	
a. Your ability to have an erection?.....	1	2	3	4	5	57/
b. Your ability to reach orgasm (climax)?.....	1	2	3	4	5	58/

9. How would you describe the usual **QUALITY** of your erections **during the last 4 weeks?**

None at all.....	1					
Not firm enough for any sexual activity.....	2					
Firm enough for masturbation and foreplay only.....	3					(Circle one number)
Firm enough for intercourse.....	4					59/

10. How would you describe the **FREQUENCY** of your erections **during the last 4 weeks?**

I NEVER had an erection when I wanted one.....	1					
I had an erection LESS THAN HALF the time I wanted one.....	2					
I had an erection ABOUT HALF the time I wanted one	3					(Circle one number)
I had an erection MORE THAN HALF the time I wanted one.....	4					
I had an erection WHENEVER I wanted one.....	5					60/

11. Overall, how would you rate your ability to function sexually **during the last 4 weeks?**

- Very poor..... 1
- Poor..... 2
- Fair..... 3 (Circle one number)
- Good..... 4
- Very good..... 5

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12. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks?**

- No problem..... 1
- Very small problem..... 2
- Small problem..... 3 (Circle one number)
- Moderate problem..... 4
- Big problem..... 5

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13. How big a problem **during the last 4 weeks**, if any, has each of the following been for you?
(Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Hot flashes.....	0	1	2	3	4	74/
b. Breast tenderness/enlargement..	0	1	2	3	4	75/
c. Feeling depressed.....	0	1	2	3	4	77/
d. Lack of energy.....	0	1	2	3	4	78/
e. Change in body weight.....	0	1	2	3	4	79/

THANK YOU VERY MUCH!!

Sexual Health Inventory For Men (SHIM)

When did you last have sexual intercourse?		
<input type="checkbox"/> Less than 1 month <input type="checkbox"/> Between 1 to 6 months <input type="checkbox"/> More than 6 months		
What is your current status of sexual function?		
<input type="checkbox"/> Normal (L0) <input type="checkbox"/> Erectile dysfunction (ED), able to have intercourse (L1A ED IC+) <input type="checkbox"/> Erectile dysfunction (ED), able to have intercourse only with the aid of an ED medication (L1B ED IC+ RX) <input type="checkbox"/> Erectile dysfunction (ED), unable to have intercourse despite use of an ED medication (L2 ED IC- RX) <input type="checkbox"/> No erection (L3) <input type="checkbox"/> I require the use of a penile prosthesis or pump (LP) <input type="checkbox"/> Abstinence (LX) <input type="checkbox"/> I don't know (LU)		
If you use a medication for erectile dysfunction, please check the medications that you currently use.		
<input type="checkbox"/> None <input type="checkbox"/> Viagra <input type="checkbox"/> Cialis <input type="checkbox"/> Levitra <input type="checkbox"/> Other, please specify: _____		
What is your confidence in getting and keeping an erection?	WITH Med(s)	WITHOUT Med(s)
0) No attempt		
1) Very low		
2) Low		
3) Moderate		
4) High very high		
5) Very High		
How often are your erections had hard enough for penetration?		
0) No attempt		
1) Almost never		
2) A few times		
3) Less than 50% of the time		
4) More than 50% of the time		
5) Almost always		
Are you able to maintain an erection after penetration?		
0) No attempt		
1) Almost never		
2) A few times		
3) Less than 50% of the time		
4) More than 50% of the time		
5) Almost always		
Is it difficult to maintain an erection until completion?		
0) No attempt		
1) Extremely difficult		
2) Very difficult		
3) Difficult		
4) Slightly difficult		
5) Not difficult		
How often was sexual intercourse satisfaction?		
0) No attempt		
1) Almost never		
2) A few times		
3) Less than 50% of the time		
4) More than 50% of the time		
5) Almost always		
Total SHIM	Date:	