**Male Symptom QuestionnaireMale Symptom Questionnaire**

**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** |
| **1. Incomplete Emptying:** How often have you had the sensation of not emptying your bladder? | 0 | 1 | 2 | 3 | 4 | 5 |
| **2. Frequency:** How often have you had to urinate less than every two hours? | 0 | 1 | 2 | 3 | 4 | 5 |
| **3. Intermittency:** How often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| **4. Urgency:** How often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **5. Weak Stream:** How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| **6. Straining:** How often have you had to strain to start urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **7. Nocturia:** How many times did you typically get up at night to urinate? | 0 | 1 | 2 | 3 | 4 | 5 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Quality of Life Due to Urinary Symptoms | Delighted | Pleased | MostlySatisfied | Mixed | MostlyDissatisfied | Unhappy | Terrible |
| If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? | **0** | **1** | **2** | **3** | **4** | **5** | **6** |
| **Have you had or do you still have:** |  **YES** |  **NO** |
| **Urge Incontinence**: Strong need to urinate followed by leaking |  |  |
| **Stress Incontinence**: Leaking with a cough, sneeze or laugh |  |  |
| **Urinary Retention**: Unable to urinate requiring a catheter |  |  |
| Blood in urine |  |  |
| Kidney Stones |  |  |
| Testicular Pain |  |  |
| Elevated PSA |  |  |
| Abnormal Prostate Exam |  |  |
| Biopsy of Prostate |  |  |
| Chronic Prostatitis |  |  |
| Kidney, Bladder or Urinary Infections |  |  |
| Surgery or Radiation of the prostate, kidneys, bladder, testicles,penis or colon? |  |  |
| **Have you seen an Urologist before?** |  |  |
| **Do you have Erectile Dysfunction?**   If yes, please continue |  |  |
| Which drugs have you tried? |  None |  Cialis |  Viagra |  Levitra |
| Which one worked without significant side effects? |  |  |  |  |  **CLINICAL USE ONLY** **IPSS Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Select any other treatments tried |  Vacuum Device | Muse | Penile Injection | Penile Prosthesis |
| Have you had your testosterone checked? |  |  |  |  |