

# URINARY SYMPTOMS VARIABLE SCORE

**(CIRCLE ONE NUMBER ON EACH LINE)**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

ANSWER ALL QUESTIONS BELOW	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
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
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
Over the past month, how often have you had to stop and start again several times while urinating?	0	1	2	3	4	5
Over the past month how often have you found it difficult to postpone (delay) urinating?	0	1	2	3	4	5
Over the past month, how often have you had a weak stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times have you typically had to get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
Over the past month, how often have you found it more difficult to urinate at night or with your first attempt in the morning?	0	1	2	3	4	5
How many extra glasses of fluid do you usually drink in a 24-hour period?	0	1	2	3	4	5
Do you take any blood pressure medication or diuretics (water pills) that would increase your urination?	Not at all	YES	Please list:			
Have you taken vitamins, minerals, or nutritional supplements?	Not at all	YES	Please list:			
Are your erections adequate for Intercourse?	Never	25%	50%	75%	Always	
Are your erections firm enough for penetration?	Soft, unable to penetrate	Decreased 25%	Decreased 50%	Decreased 75%	Always firm	