

Start by touching TAB to select first field, then touch TAB to proceed through the remaining fields.  
The SPACE BAR (or mouse click) will check off selected choices in question fields.

## 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
<b>1. Incomplete Emptying</b> How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
<b>2. Frequency</b> How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
<b>3. Intermittency</b> How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
<b>4. Urgency</b> How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
<b>5. Weak Stream</b> How often have you had a weak urinary stream?	0	1	2	3	4	5	
<b>6. Straining</b> How often have you had to strain to start urination?	0	1	2	3	4	5	
	<b>None</b>	<b>1 Time</b>	<b>2 Times</b>	<b>3 Times</b>	<b>4 Times</b>	<b>5 Times</b>	
<b>7. Nocturia</b> How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
<b>Total I-PSS Score</b>							

**Score:**      1-7: *Mild*                      8-19: *Moderate*                      20-35: *Severe*

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 just the way it is now, how would you feel about that?	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>

### **About the I-PSS**

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms and one question concerning quality of life. Each question concerning urinary symptoms allows the patient to choose one out of six answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The questions refer to the following urinary symptoms:

<b>Questions</b>	<b>Symptom</b>
1	Incomplete emptying
2	Frequency
3	Intermittency
4	Urgency
5	Weak Stream
6	Straining
7	Nocturia

Question eight refers to the patient's perceived quality of life.

The first seven questions of the I-PSS are identical to the questions appearing on the American Urological Association (AUA) Symptom Index which currently categorizes symptoms as follows:

- Mild (symptom score less than or equal to 7)
- Moderate (symptom score range 8-19)
- Severe (symptom score range 20-35)

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), recommends the use of only a single question to assess the quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of benign prostatic hyperplasia (BPH) Symptoms or quality of life, it may serve as a valuable starting point for a doctor-patient conversation.

The SCI has agreed to use the symptom index for BPH, which has been developed by the AUA Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.

The SCI recommends that physicians consider the following components for a basic diagnostic workup: history; physical exam; appropriate labs, such as U/A, creatine, etc.; and DRE or other evaluation to rule out prostate cancer.

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EPIC-26  
The Expanded Prostate Cancer Index Composite  
Short Form

This questionnaire is designed to measure Quality of Life issues in patients with Prostate cancer. To help us get the most accurate measurement, it is important that you answer all questions honestly and completely.

Remember, as with all medical records, information contained within this survey will remain strictly confidential.

Today's Date (please enter date when survey completed): Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Name (optional): \_\_\_\_\_

Date of Birth (optional): Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

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 (Check 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 (Check 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 (Check 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?

(Check 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						31/
or incomplete emptying .....	0	1	2	3	4	
e. Need to urinate frequently						33/
during the day .....	0	1	2	3	4	

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 (Check 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? (Check 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
b. Increased frequency of bowel movements.....	0	1	2	3	4
c. Losing control of your stools.....	0	1	2	3	4
d. Bloody stools .....	0	1	2	3	4
e. Abdominal/ Pelvic/Rectal pain...	0	1	2	3	4

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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 (Check one number)
- Moderate problem..... 4
- Big problem..... 5

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8. How would you rate each of the following during the last 4 weeks? (Check 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
b. Your ability to reach orgasm (climax)?.....	1	2	3	4	5

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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 (Check one number)
- Firm enough for intercourse..... 4

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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 (Check one number)
- I had an erection MORE THAN HALF the time I wanted one..... 4
- I had an erection WHENEVER I wanted one..... 5

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

- Very poor..... 1
- Poor..... 2
- Fair..... 3 (Check 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 (Check 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?

(Check 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
b. Breast tenderness/enlargement..	0	1	2	3	4
c. Feeling depressed.....	0	1	2	3	4
d. Lack of energy.....	0	1	2	3	4
e. Change in body weight.....	0	1	2	3	4

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THANK YOU VERY MUCH!!

# Sexual Health Inventory For Men (SHIM)

Protocol: \_\_\_\_\_

Participant ID or #: \_\_\_\_\_

<b>When did you last have sexual intercourse?</b>		
<input type="checkbox"/> Less than 1 month <input type="checkbox"/> Between 1 to 6 months <input type="checkbox"/> More than 6 months		
<b>What is your current status of sexual function?</b>		
<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)		
<b>If you take medication for erectile dysfunction, please select medications that you currently use below.</b>		
<input type="checkbox"/> None <input type="checkbox"/> Viagra <input type="checkbox"/> Cialis <input type="checkbox"/> Other, please specify: _____		
<b>What is your confidence in getting and keeping an erection?</b>	<b>WITH Med(s)</b>	<b>WITHOUT Med(s)</b>
0) No Attempt		
1) Very Low		
2) Low		
3) Moderate		
4) High / Very High		
5) Very High		
<b>How often are your erections hard enough for penetration?</b>	<b>WITH Med(s)</b>	<b>WITHOUT Med(s)</b>
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		
<b>Are you able to maintain an erection after penetration?</b>	<b>WITH Med(s)</b>	<b>WITHOUT Med(s)</b>
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		
<b>Is it difficult to maintain an erection until completion?</b>	<b>WITH Med(s)</b>	<b>WITHOUT Med(s)</b>
0) No Attempt		
1) Extremely Difficult		
2) Very Difficult		
3) Difficult		
4) Slightly Difficult		
5) Not Difficult		
<b>How often was sexual intercourse satisfying?</b>	<b>WITH Med(s)</b>	<b>WITHOUT Med(s)</b>
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		
<b>Total SHIM</b>		
<b>Date:</b>		