



American Urological Association AUA SYMPTOM SCORE

Radiation Oncology Department

FOR PROSTATE CANCER PATIENTS: Please fill out the following questionnaire.

The American Urological Association (AUA) has drafted a simple symptom index to help categorize urinary symptoms. This information will assist your physicians and nurses in evaluating symptoms if they arise during your care in our department. Thank you for your assistance.

For the following questions (please circle the number below each question):

- 0** Not at all (0%)
- 1** Less than 1 time in 5 (<20%)
- 2** Less than half the time (<50%)
- 3** About half the time (~50%)
- 4** More than half the time (>50%)
- 5** Almost always (~100%)

INCOMPLETE EMPTYING

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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FREQUENCY

Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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INTERMITTENCY

Over the past month, how often have you found that you stopped and started again several times when you urinated?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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URGENCY

Over the past month, how often have you found it difficult to postpone urination?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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WEAK-STREAM

Over the past month, how often have you had a weak stream?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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STRAINING

Over the past month, how often have you had to push or strain to begin urination?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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NOCTURIA

Over the past month, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input checked="" type="radio"/> 5
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Quality of Life Due to Urinary Symptoms (Please circle one answer below)

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?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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