

**CAPITAL UROLOGY, INC.**

**American Urological Association Symptom Index**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date completed \_\_\_\_\_

<b>Over the past month:</b>	<b>Not at All</b>	<b>Less than 1 in 5 Times</b>	<b>Less than Half the Time</b>	<b>About Half the Time</b>	<b>More than Half the Time</b>	<b>Almost Always</b>	<b>Your score</b>
1. How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. How often have you had to push or 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 or More</b>	
7. How many times did you typically get up at night to urinate from the time you went to bed at night until you got up in the morning?	0	1	2	3	4	5	
<b>Total Score =</b>							

<b>Quality of Life Due to Urinary Symptoms</b>	<b>Delighted</b>	<b>Pleased</b>	<b>Mostly Satisfied</b>	<b>Mixed</b>	<b>Mostly Dissatisfied</b>	<b>Unhappy</b>	<b>Terrible</b>
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>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>