Check the facts

ABOUT YOUR URINARY ACTIVITIES

Patient Name _____

Circle your score for each 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
1 Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2 Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3 Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4 Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5 Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6 Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

	None	1 time	2 times	3 times	4 times	5 or more times
7 Over the last month, how many times did you most typically 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

From the American Urological Association (AUA) Symptom Index for BPH

Total your score here.

Total Symptom Score = Sum of Questions 1 to 7 = ☐