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Cancer Care Center

Advocate Good Samaritan Hospital

Dear Patient:

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. We are interested in your answers to help us improve the quality of care we are giving our patients with prostate cancer. We appreciate your cooperation in our effort to positively impact our patients.

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

Today's Date (date survey completed):

Month _____Day _____ Year _____

Name: _____

Date of Birth: _____

INTERNATIONAL PROSTATE SYMPTOM SCORE

	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	Your score
1. **Incomplete Emptying:** Over the past month, how often have you had a sensation of not emptying your bladder completely after you've finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	
2. **Frequency:** 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**	
3. **Intermittency:** Over the past month, how often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**	
4. **Urgency:** Over the past month, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**	
5. **Weak stream:** Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**	
6. **Straining:** Over the past month, how often have you had to push or strain to being urination?	**0**	**1**	**2**	**3**	**4**	**5**	
7. **Nocturia:** Over the past 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**	

Quality of life due to urinary symptoms	**Delighted**	**Pleased**	**Mostly Satisfied**	**Equally Satisfied and Dissatisfied**	**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 it?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

Total Score (for this page) _____

URINARY FUNCTION

This section is about your urinary habits. Please consider **ONLY THE LAST 4 WEEKS.**

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
About once a week?	4
Rarely or never?	5

Circle one number

2. Over the **past 4 weeks**, how often have you urinated blood?

More than once a day?	1
About once a day?	2
More than once a week?	3
About once a week?	4
Rarely or never?	5

Circle one number

3. Over the **past 4 weeks**, how often have you had pain or burning with urination?

More than once a day?	1
About once a day?	2
More than once a week?	3
About once a week?	4
Rarely or never?	5

Circle one number

4. Which of the following best describes your urinary control **during the last 4 weeks**?

No urinary control whatsoever?	1
Frequent dribbling?	2
Occasional dribbling?	3
Total control?	4

Circle one number

5. How many pads or adult diapers per day have you used to control leakage during the last **4 weeks?**

None	1
1 pad per day?	2
2 pads per day?	3
3 or more pads per day?	4

Circle one number

6. How big a problem, if any, has each of the following been for you **during the last 4 weeks?**

(Circle one number for each line)

	No Problem	**Very Small Problem**	**Small Problem**	**Moderate Problem**	**Big Problem**
Dripping or leaking urine?	0	1	2	3	4
Pain or burning on urination?	0	1	2	3	4
Bleeding with urination?	0	1	2	3	4
Weak urine stream or incomplete emptying?	0	1	2	3	4
Waking up to urinate?	0	1	2	3	4
Need to urinate frequently during the day?	0	1	2	3	4

7. 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
Moderate problem	4
Big problem	5

Circle one number

BOWEL HABITS
The next section is about your bowel habits and abdominal pain. Please consider **ONLY THE LAST 4 WEEKS.**

1. How often have you had rectal urgency (felt like I had to pass stool, but did not) **during the last 4 weeks**?

More than once a day?	1
About once a day?	2
More than once a week?	3
About once a week?	4
Rarely or never?	5

Circle one number

2. How often have you had uncontrolled leakage of stool or feces?

More than once a day?	1
About once a day?	2
More than once a week?	3
About once a week?	4
Rarely or never?	5

Circle one number

3. How often have you had stools (bowel movements) that were loose or liquid (no form, watery, mushy) **during the last 4 weeks**?

Never	1
Rarely	2
About half the time	3
Usually	4
Always	5

Circle one number

4. How often have you had bloody stools **during the last 4 weeks**?

Never	1
Rarely	2
About half the time	3
Usually	4
Always	5

Circle one number

5. How often have your bowel movements been painful **during the last 4 weeks**?

Never	1
Rarely	2
About half the time	3
Usually	4
Always	5

Circle one number

6. How many bowel movements have you had on a typical day **during the last 4 weeks**?

Two or less	1
Three to four	2
Five or more	3

Circle one number

7. How often have you had crampy pain in your abdomen, pelvis, or rectum **during the last 4 weeks**?

More than once a day	1
About once a day	2
More than once a week	3
About once a week	4
Rarely or never	5

Circle one number

8. How big a problem, if any, has each of the following been for you? (Circle one number for each line)

		No Problem	**Very Small Problem**	**Small Problem**	**Moderate Problem**	**Big Problem**
a.	Urgency to have a bowel movement?	**0**	**1**	**2**	**3**	**4**
b.	Increased frequency of bowel movement?	**0**	**1**	**2**	**3**	**4**
c.	Watery bowel movements?	**0**	**1**	**2**	**3**	**4**
d.	Losing control of your stools?	**0**	**1**	**2**	**3**	**4**
e.	Bloody stools?	**0**	**1**	**2**	**3**	**4**

9. 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
Moderate problem	4
Big problem	5

Circle one number

SEXUAL HEALTH INVENTORY FOR MEN

Patient Instructions:

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify whether you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of responses that **best describes** your own situation. Please be sure that you select one and only **one response for each question.**

During the past 6 months:

1. How do you rate your **confidence** that you could get and keep an erection?

Very low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you have an erection with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

3. During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

4. During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, **how often** was it satisfactory to you?

Did not attempt intercourse	Never	A few times	Sometimes	Most times	Always
0	1	2	3	4	5

Total Score (for this page) _____

Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak with your doctor.