EL CAMINO UROLOGY MEDICAL GROUP
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Over the past month, typically how often have you experienced:	Not at all	Less than 1 time in 5.	Less than half of the time.	About half of the time.	More than half of the time.	Almost Always.
INCOMPLETE EMPTYING A sensation of not emptying your bladder completely after you finished urinating.	0	1	2	3	4	5
FREQUENCY Urinating again less than 2 hours after you finished urinating.	0	1	2	3	4	5
INTERMITTENCY Stopping and starting again several times when you urinate.	0	1	2	3	4	5
URGE TO URINATE Finding it difficult to postpone urination.	0	1	2	3	4	5
WEAK STREAM Minimal urinary stream.	0	1	2	3	4	5
STRAINING Needing to push or strain to begin urination.	0	1	2	3	4	5
URINATING AT NIGHT Number of times you 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

How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

Do you have a decrease in libido (sex drive)? YES or NO

Do you have lack of energy? YES or NO

Do you have a decrease in strength and/or endurance? YES or NO

Have you lost height? YES or NO

Have you noticed a decreased “enjoyment of life”? YES or NO

Are you sad and/or grumpy? YES or NO

Are your erections less strong? YES or NO

Have you noticed a recent deterioration in your ability to play sports? YES or NO

Are you falling asleep after dinner? YES or NO

Has there been a recent deterioration in your work performance? YES or NO

What is your main concern that you would like the doctor to address?

Patient Name: _____

Today’s Date: _____ **MD Initials:** _____ **Date:** _____