

International Prostate Symptom Score (IPSS)

Patient Name:

Date of Birth:

Age:

Today's Date:

Determine Your BPH Symptoms

 Circle your answers and add up your scores
 at the bottom.

| Over the past month | Not at all | Less than one time in five | Less than half the time | About half the time | More than half the time | Almost always |
|--|------------|----------------------------|-------------------------|---------------------|-------------------------|----------------------------|
| Incomplete emptying - How often have you had the sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| Frequency - How often have you had to urinate again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| Intermittency - How often you have found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| Urgency - How often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| Weak stream - How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| Straining - How often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| Sleeping - 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? | None 0 | One Time 1 | Two Times 2 | Three Times 3 | Four Times 4 | Five or More Times 5 |
| Add Symptom Scores: | | - | - | - | - | - |

**Total International Prostate
 Symptom Score=**
1-7 mild symptoms - 8-19 moderate symptoms - 20-35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

| Quality of Life (QoL) | Delighted | Pleased | Mostly Satisfied | Mixed | Mostly Dissatis- | 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 that? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

| | | |
|--|------------|-----------|
| Would you be interested in treatment options? | Yes | No |
|--|------------|-----------|