

## AUA SYMPTOM SCORE

<b>Last Name</b>	<b>First Name</b>	<b>Date</b>

**Highlight or bold or change font color of the response correct for you and type in your score in the far right box for all SEVEN questions.**

1. **Incomplete emptying:** Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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
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?

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
0	1	2	3	4	5	

3. **Intermittency:** Over the past month, how often have you found that you stopped and started again several times when you urinated?

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
0	1	2	3	4	5	

4. **Urgency:** Over the past month, how often have you found it difficult to postpone urination?

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
0	1	2	3	4	5	

5. **Weak-stream:** Over the past month, how often have you had a weak stream?

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
0	1	2	3	4	5	

6. **Straining:** Over the past month, how often have you had to push or strain to begin urination?

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
0	1	2	3	4	5	

7. **Nocturia:** Over the past month or so, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

None	1 time	2 times	3 times	4 times	5 or more times	Your Score
0	1	2	3	4	5	

**Add up your scores for total AUA score = \_\_\_\_\_**

**Quality of Life Due to Urinary Symptoms:** 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? (Bold, Highlight or Underline)

Delighted      Pleased      Mostly satisfied      Mixed      Mostly dissatisfied      Unhappy      Terrible