UROLOGY SAN ANTONIO

URINARY SYMPTOM SCREENER (AUA SYMPTOM SCORE)

Patient Name: _____ Date: _____

Circle the number that best describes your experience.	NOT AT ALL	LESS THAN 1 TIMES IN 5	LESS THAN ½ THE TIME	ABOUT ½ THE TIME	MORE THAN ½ THE TIME	ALMOST ALWAYS
1. INCOMPLETE EMPTYING 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. FREQUENCY Over the past month or so, 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 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. URGENCY Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. NOCTURIA Over the past month or so, how many times did you typically get up to urinate from the time you went to bed until the time you got up in the morning?	**None** 0	**1 Time** 1	**2 Times** 2	**3 Times** 3	**4 Times** 4	**5 Times** 5

Add the score for each question above, and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe TOTAL _____

QUALITY OF LIFE: 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**