Incontinence Symptom Index

This brief questionnaire is designed to assess the severity of your urinary incontinence (involuntary urine leakage). For each question, please mark the number associated with the response that best describes your voiding habits during the past month.

During the past Month…	Never	Rarely	Occasionally	About Half the time	Most or all the time
1. How Often has urine leakage occurred in association with any physical activity (such as lifting, bending, sitting down, standing up, exercise, etc) ?	0	1	2	3	4
2. How often has lifting light objections (such as a gallon of milk) caused you to leak urine?	0	1	2	3	4
3. How often has walking or light exercise caused you to leak urine?	0	1	2	3	4
	Never	Seldom	About once a week	About once a day	More than once a day
4. How often have you leaked urine because you could not wait to empty your bladder?	0	1	2	3	4
5. How often has a sudden urge to urinate caused you to leak urine?	0	1	2	3	4
6. How often have you leaked urine because you could not reach a bathroom in time?	0	1	2	3	4
	None	Thin Pad of tissue	Medium/Regular Pad	Large/Maxi Pad	Absorbent, disposable, undergarments
7. On average, what form of protection do you use to protect against wetness during the day?	0	1	2	3	4
	None	1 per day or less, or only for security	1 per day and it is usually wet	2-3 per day	4 or more per day
8. On average, how many of these (pads, tissues, disposable undergarments) would you use to protect against wetness during the day?	0	1	2	3	4

Total Severity Score________________

	Never	Rarely	Sometimes	Most of the time	All of the time
9. Overall, how often have you needed to change your daily activities because of your urinary incontinence?	0	1	2	3	4
	No problem	Very small problem	Small problem	Moderate problem	Big problem
10. Overall, how big of a social problem (anxiety, embarrassment, avoiding social activities) has your urinary incontinence been for you during the past month?	0	1	2	3	4

Total Bother Score:_________________

International Prostate Symptom Score (IPSS)

____

Patient Name **Date**

Circle the number that best applies to you

	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost always	Notes:
1. Incomplete Emptying Over the last month, how often have you had a sensation of not emptying after you finish urinating?	⓪	①	②	③	④	⑤	
2. Frequency During the last month, how often have you had to urinate again less than two hours after you finished urinating?	⓪	①	②	③	④	⑤	
3. Intermittency During the last month, how often have you stopped and started again several times when you urinate?	⓪	①	②	③	④	⑤	
4. Urgency During the last month, how often have you found it difficult to postpone urination?	⓪	①	②	③	④	⑤	
5. Weak Stream During the last month, how often have you had a weak urinary stream?	⓪	①	②	③	④	⑤	
6. Straining During the last month, how often have you had to push or strain to begin urination?	⓪	①	②	③	④	⑤	
7. Nocturia During the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	⓪	①	②	③	④	⑤	

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

SYMPTOM SCORE: 1-7=MILD 8-19=MODERATE 20-35=SEVERE

8. 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 Not Satisfied	Unhappy
	⓪	①	②	③	④	⑤

Have you tried Medications to help your symptoms?	Yes	No

Did these Medications help your symptoms? (circle)

No Relief *Completely Cured*

1	2	3	4	5

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME:_______________________________________ TODAYS DATE:________________

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

OVER THE LAST 6 MONTHS

Question						
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 had erections 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 complete 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 for you?	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