

## International Prostate Symptom Score (I-PSS)

**Please bold or circle the appropriate number**

**Patient Name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_ **Date completed** \_\_\_\_\_

<b>In the past month:</b>	<b>Not at All</b>	<b>Less than 1 in 5 Times</b>	<b>Less than Half the Time</b>	<b>About Half the Time</b>	<b>More than Half the Time</b>	<b>Almost Always</b>
<b>1. Incomplete Emptying</b> How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5
<b>2. Frequency</b> How often have you had to urinate less than every two hours?	0	1	2	3	4	5
<b>3. Intermittency</b> How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>4. Urgency</b> How often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>5. Weak Stream</b> How often have you had a weak urinary stream?	0	1	2	3	4	5
<b>6. Straining</b> How often have you had to strain to start urination?	0	1	2	3	4	5
	<b>None</b>	<b>1 Time</b>	<b>2 Times</b>	<b>3 Times</b>	<b>4 Times</b>	<b>5 Times</b>
<b>7. Nocturia</b> How many times did you typically get up at night to urinate?	0	1	2	3	4	5
<b>Total I-PSS Score</b>						

**Score:**      1-7: *Mild*                      8-19: *Moderate*                      20-35: *Severe*

<b>Quality of Life Due to Urinary Symptoms</b>						
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 or circle the appropriate result)						
Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	1	2	3	4	5	6