International Prostate Symptom Score (IPSS)
Naeem T. Chavla, MD

Name: _____ Date of Birth: _____
Date Completed: _____ Patient Signature: _____

	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	
1. Incomplete Emptying Over the past month, 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, how often have you had to urinate again less than 2 hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	
3. Intermittency / Dribbling Over the past month, how often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**	
	None	1 time	2 times	3 times	4 times	5 or more times	
7. Nocturia Over the past month, 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?	**0**	**1**	**2**	**3**	**4**	**5**	
						TOTAL IPSS Score:	
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	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**

I have/had burning or pain when I urinate. **Yes** or **No**
I have/had urinary tract infection (UTI) before. **Yes** or **No**
I have/had urinary incontinence with urgency. **Yes** or **No**
I have seen blood in my urine. **Yes** or **No**
When I use the bathroom, I have to wait a long time to begin urinating. **Yes** or **No**
Please circle if you have/had occupational exposure to working in **paper / dying / rubber** industry.
I have/had urinary retention (the inability to urinate). **Yes** or **No**
Has the problem of incontinence affected your quality of life? **Yes** or **No**
Please circle if applicable: I frequently experience pain in my **prostate / rectum** or **behind the testicles.**
I find it difficult to achieve/maintain an erection during sexual relations and wish to discuss it with the doctor. **Yes** or **No**
I have problems with premature ejaculation. **Yes** or **No**
I have problems having an orgasm. **Yes** or **No**
I have problems with the curvature of my penis. **Yes** or **No**