FORM NUMBER = (FORM)
FORM VERSION = (VERS)

NIH - BPH TRIAL

AUA SYMPTOM QUESTIONNAIRE

This form is to be completed at screening visits 1 & 2, and quarterly follow-up visits (not titration visits). The patient should complete pages 2 through 3.

Part I / IDENTIFICATION

A. Patient Identification

1. Clinic number **(CLINIC)** ☐☐

2. Patient Identification number (Complete a **OR** b)

   a. If before randomization, Screening number **(SCREEN)** S☐☐☐☐

   b. If after randomization, Patient number **(PATID)** ☐☐☐☐☐ (clinic / patient)

3. Patient's initials **(INITS)** ☐☐☐☐ (first / last)

4. Patient's date of birth **(DOB)** ☐☐ ☐☐ ☐☐ (month / day / year)

B. Visit Information

1. Date of visit **(QVSTDT)** ☐☐ ☐☐ ☐☐ (month / day / year)

2. Type of visit **(QVITYP)**

- [1] Screening
- [2] Interim Follow-up
- [3] Standard Follow-up
- [4] Major Follow-up
- [5] End of Study

3. If Follow-up visit or End of Study, week of visit **(QVIWK)** ☐☐☐

Part II / SYMPTOM SCORE QUESTIONNAIRE

The patient should complete the questionnaire on the following 2 pages.

Initials of person completing form **(FORMIN)** ☐☐☐☐ (first / last) Form entered in computer? ☐

Patient number ☐☐☐☐☐ Date of visit ☐☐ / ☐☐ / ☐☐
month day year

A: SYMPTOM SCORE

Please put an "X" in the box for the answer that best describes your symptoms.

	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. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating? **(QSSEMP)**	0	1	2	3	4	5
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating? **(QSSAGN)**	0	1	2	3	4	5
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated? **(QSSSEV)**	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urination? **(QSSPOST)**	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream? **(QSSWEAK)**	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination? **(QSSPUSH)**	0	1	2	3	4	5

7. Over the last 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? **(QSSNIT)**

☐0 none ☐1 1 time ☐2 2 times ☐3 3 times ☐4 4 times ☐5 5 or more times

AUA Symptom Score = Add questions A1 - A7 ☐☐

(QSSADD)

Please initial here _____

Patient number ☐☐☐☐☐ Date of visit ☐☐ / ☐☐ / ☐☐ (month / day / year)

B: IMPACT INDEX

Please put an "X" in the box for the answer that best describes your symptoms.

1. Over the past month, how much physical discomfort did any urinary problems cause you? **(QQLDISC)**

☐ 0 none ☐ 1 only a little ☐ 2 some ☐ 3 a lot

2. Over the past month, how much did you worry about your health because of any urinary problems? **(QQLHLTH)**

☐ 0 none ☐ 1 only a little ☐ 2 some ☐ 3 a lot

3. Overall, how bothersome has any trouble with urination been during the past month? **(QQLBOTH)**

☐ 0 not at all bothersome ☐ 1 bothers me a little ☐ 2 bothers me some ☐ 3 bothers me a lot

4. Over the past month, how much of the time has any urinary problem kept you from doing the kinds of things you would usually do? **(QQLKEPT)**

☐ 0 none of the time
☐ 1 a little of the time
☐ 2 some of the time
☐ 3 most of the time
☐ 4 all of the time

C: QUALITY OF LIFE DUE TO URINARY PROBLEMS

Please put an "X" in the box for the answer that best describes your symptoms.

1. 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? **(QQLFEEL)**

☐ 0 delighted
☐ 1 pleased
☐ 2 mostly satisfied
☐ 3 mixed (about equally satisfied and dissatisfied)
☐ 4 mostly dissatisfied
☐ 5 unhappy
☐ 6 terrible

Please initial here _____