Cancer Care
International Prostate Symptom Score

Frederick Health

PATIENT NAME _____ DATE OF BIRTH ____/____/____ DATE ____/____/____

Please circle the answer that best describes your response to each of the following questions:

	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	Over ½ the time	Almost always
Incomplete Emptying In 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
Frequency In 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
Intermittency In the past month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency In the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream In the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Straining In the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Nocturia In the past month, how many times did you typically get up to urinate between going to bed at night and getting up in the morning (on average)?	0	1	2	3	4	5

Total score: _____

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	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