Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

International Prostate Symptom Score

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month | Day | Year

Please fill in the oval that *best describes* your response to each question.

Select only one response for each question.

In the past month:	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying How often have you had the sensation of not emptying your bladder?	⬭	⬭	⬭	⬭	⬭	⬭
Frequency How often have you had to urinate less than every two hours?	⬭	⬭	⬭	⬭	⬭	⬭
Intermittency How often have you found you stopped and started again several times when you urinated?	⬭	⬭	⬭	⬭	⬭	⬭
Urgency How often have you found it difficult to postpone urination?	⬭	⬭	⬭	⬭	⬭	⬭
Weak stream How often have you had a weak urinary stream?	⬭	⬭	⬭	⬭	⬭	⬭
Straining How often have you had to strain to start urination?	⬭	⬭	⬭	⬭	⬭	⬭

In the past month:	None	1 Time	2 Times	3 Times	4 Times	5 Times
Nocturia How many times did you typically get up at night to urinate?	⬭	⬭	⬭	⬭	⬭	⬭