ADVANCED ONCOLOGY SPECIALISTS

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AUA SYMPTOM SCORE

Patient Name: _____ Date: _____

Instructions: For each question, select the number that best describes your symptoms over the past month. The questions are designed to gauge the severity of any symptoms you may be experiencing**.**

	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 have 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 have finished urinating?	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○
3. Intermittency: 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** ○
7. Noeturia: 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** ○

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

Total: _____

Quality of Life due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	**0** ○	**1** ○	**2** ○	**3** ○	**4** ○	**5** ○	**6** ○