

**MANCHESTER UROLOGY ASSOCIATES AT DOVER**

**NAME:**

**DATE OF BIRTH:**

**DATE:**

**USE LAST MONTH AS A GUIDE**

	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
<b>1) Incomplete Emptying</b> How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
<b>2) Frequency</b> How often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
<b>3) Intermittency</b> How often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
<b>4) Urgency</b> How often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>5) Weak Stream</b> How often have you had a weak urinary stream?	0	1	2	3	4	5
<b>6) Straining</b> 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 Times or more
<b>7) Nocturia</b> How many times on an average do you get up to urinate after you go to bed?	0	1	2	3	4	5
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy
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