

International Prostate Symptom Score (I-PSS)

Patient Name: _____ Date of birth: _____ Date completed _____

| | 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 | Your score |
|--|-------------|------------------------|-------------------------|---------------------|-------------------------|------------------|------------|
| 1. Incomplete Emptying How often have you had the sensation of not emptying your bladder? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 2. Frequency How often have you had to urinate less than every two hours? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 3. Intermittency How often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 4. Urgency How often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 5. Weak Stream How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 6. Straining How often have you had to strain to start urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| | None | 1 Time | 2 Times | 3 Times | 4 Times | 5 or More | |
| 7. Nocturia How many times did you typically get up at night to urinate? | 0 | 1 | 2 | 3 | 4 | 5+ | |
| Total I-PSS Score | | | | | | | |

| 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 just the way it is now, how would you feel about that? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |