UHMP Urology: American Urological Association Symptom Index

Patient Name: ____
(Last Name First Name)
Date of Birth: ________________ Date Completed: _____________________

Over 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	Your Score
1. How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. How often have you had to urinate again less than two hours after your finished urinating?	0	1	2	3	4	5	
3. How often have you found you stopped an started again several times when you urinated?	0	1	2	3	4	5	
4. How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. How often have you had to push or strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 times**	**3 times**	**4 Times**	**5 or More**	
7. How many times did you typically get up at night to urinate from time you went to bed at night until you got up in the morning?	0	1	2	3	4	5	
Total 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 ?	1	2	3	4	5	6	7