

American Urological Association Symptom Score Index

Patient Name: _____

Date: _____

	Never	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
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	
Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
Nocturia Over the past month, how many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	Never 0	1 time 1	2 times 2	3 times 3	4 times 4	5 times or more 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?							