

Patient Assessment Questionnaire: For Females Only

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for your doctor to assess your answers. Please do not mark anything in these columns.

Patient's Name: _____ Today's Date: _____

	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19			
2. a. how many times a day do you go to the bathroom at night?	0	1	2	3	4+		
b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? Yes ___ No ___							
4. a. IF YOU ARE SEXUALLY ACTIVE, do you now or have ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7. a. If you have pain, is it usually...	Never	Mild	Moderate	Severe			
b. does your pain bother you?	Never	Occasionally	Usually	Always			
8. a. If you have urgency, is it usually...	Never	Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			

<u>Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a) - Subtotal</u>		
<u>Bother Score (2b, 4b, 7b, 8b) - Subtotal</u>		
<u>Total Score (Symptom Score + Bother Score) =</u> _____		