

Hunterdon Urological Associates

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Patient Name: _____	None of the Time	Rarely	Once in Awhile	Often	Most of the Time	All of the Time
Patient Date of Birth: _____						
Consulting Provider: _____						
Consult Date: _____ Consult time: _____						
Do you leak urine (<i>even small drops</i>), wet yourself, or wet your pads or undergarments...						
1. When you cough or sneeze?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When you bend down or lift something up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When you walk quickly, jog or exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. While you are undressing in order to use the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have to rush to the bathroom because you get a sudden, strong need to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring: 0 (none of the time), 1 (Rarely), 2 (Once in a while), 3 (Often), 4 (Most of the Time), or 5 (All of the Time).

Responses to items 1, 2 and 3 are summed for the Stress score; and responses to items 4, 5, and 6 are summed for the Urge score.

Patient's Stress Score: _____

Patient's Urge Score: _____

International Prostate Symptom Score (IPSS)

Patient Name: _____

Today's Date: _____

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	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

Have you tried medications to help your symptoms? Yes No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10
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No Relief

Complete Relief

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications? Yes No