

# Center for Urologic & Pelvic Pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## AUA Symptom Index

### Part A – Urinary Symptoms (Please circle the correct answer)

	<u>Not at all</u>	<u>Less than 1 time in 5</u>	<u>Less than half the time</u>	<u>About half the time</u>	<u>More than half the time</u>	<u>Almost always</u>
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Over the past month, 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? _____ (0 = none, 1 = 1 time, 2 = 2 times, 3 = 3 times, 4 = 4 times, 5 = 5 or more times)						

AUA Symptom Score = Sum of Questions A1 – A7: \_\_\_\_\_

### Part B – Problems Due to Symptoms

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Medium Problem</u>	<u>Big Problem</u>
1. Over the past month, how much has a sensation of not emptying your bladder been a problem for you?	0	1	2	3	4
2. Over the past month, how much has frequent urination during the day been a problem for you?	0	1	2	3	4
3. Over the past month, how much has getting up at night to urinate been a problem for you?	0	1	2	3	4
4. Over the past month, how much has stopping and starting when you urinate been a problem for you?	0	1	2	3	4
5. Over the past month, how much has a need to urinate with little warning been a problem for you?	0	1	2	3	4
6. Over the past month, how much has impaired size and force or urinary stream been a problem for you?	0	1	2	3	4
7. Over the past month, how much has having to push or strain to begin urination been a problem for you?	0	1	2	3	4

AUA Symptom Score = Sum of Questions B1 – B7: \_\_\_\_\_

## **Part C – Quality of Life Due to Urinary Problems**

1. Over the past month, how much physical discomfort did urinary problems cause you?
  - None
  - Only a little
  - Some
  - A lot
  
2. Over the past month, how much did you worry about your health because of any urinary problems?
  - None
  - Only a little
  - Some
  - A lot
  
3. Over all, how bothersome has any trouble with urination been during the recent month?
  - Not at all bothersome
  - Bothers me a little
  - Bothers me some
  - Bothers me a lot
  
4. 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?
  - Delighted
  - Pleased
  - Mostly satisfied
  - Mixed (about equally satisfied and dissatisfied)
  - Mostly dissatisfied
  - Unhappy
  - Terrible
  
5. Over the past month, how much of the time has any urinary problem kept you from doing the kinds of things you would usually do?
  - None of the time
  - A little of the time
  - Some of the time
  - Most of the time
  - All of the time