Check the facts

About your urinary activities

Name:_____ Date:_____

Circle your score for each below

	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN HALF THE TIME	ABOUT HALF THE TIME	MORE THAN HALF THE TIME	ALWAYS
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 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month or so, how often have you found that 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. How often do you typically get up to urinate during the night?	None 0	Once 1	2 times 2	3 times 3	4 times 4	5+ times 5

Total your score here

Total symptom score = sum of questions 1 thru 7 =