

POST-RADICAL PROSTATECTOMY QUESTIONNAIRE

Last Name (REQUIRED)

First Name (REQUIRED)

PHN/CARE CARD NUMBER (REQUIRED)

Date

Purpose: To track your progress following surgery. All information is strictly confidential.

PLEASE COMPLETE BOTH SIDES

PART 1: URINARY FUNCTION (Mod. MSKCC/UCLA PCI)

Instructions: These questions ask about urine leakage, **OVER THE PAST WEEK.**
Please circle ONE number for each question.

1. In the past week, how often have you leaked urine? (Check ONE number)

- 1 Not at all
- 2 Less than once per week (rarely)
- 3 About once a week
- 4 Every few days
- 5 Once a day
- 6 More than once a day

2. How many pads or adult diapers per day (24 hour period) did you usually use to control leakage during the last week? (Check ONE number)

- 1 None
- 2 An occasional pad
- 3 1 pad per 24-hour period
- 4 2 pads per 24-hour period
- 5 3 or more pads per 24-hour period

3. Which of the following best describes your urinary control? (Check ONE number)

- 1 Complete control (Continent)
- 2 Leakage with heavy activity (Mild SUI)
- 3 Leakage with moderate activity (Moderate SUI)
- 4 Leakage during normal activity, but dry at night and at rest (Severe SUI)
- 5 Continuous leakage of urine at rest (Total Incontinence)

4. In the past week, how would you describe your urinary flow? (Check ONE number)

- 1 Very strong (flows freely)
- 2 About average (good flow)
- 3 Slow (takes a long time to empty)

5. Overall, how big a problem has your urinary function been for you? (Check ONE number)

- 1 No problem
- 2 Very small problem
- 3 Small problem
- 4 Moderate problem
- 5 Big problem

PART 2: SEXUAL FUNCTION (SHIM/IIEF-5)

Instructions: These questions ask about your sexual function. This includes foreplay, masturbation, intercourse with partner and other forms of sexual activity during **DURING THE PAST 4 WEEKS**. Please answer the following questions as honestly and clearly as possible.
ALL ANSWERS ARE CONFIDENTIAL

<p>How important is sexual function to you?</p> <input type="checkbox"/> Not at all important <input type="checkbox"/> A little important <input type="checkbox"/> Moderately important <input type="checkbox"/> Very important	<p>Have you used any of the following in the last 4 weeks? (check all that apply)</p> <input type="checkbox"/> Cialis <input type="checkbox"/> Levitra <input type="checkbox"/> Viagra <input type="checkbox"/> Penis injections/ICI (e.g. Trimix or Prostaglandin)
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Mark ONLY one box per question: Please indicate if your answers reflect your sexual function

WITH ASSISTANCE (e.g. Viagra, Cialis or Levitra) OR **WITHOUT ASSISTANCE**

- | | |
|---|--|
| <p>1. <i>Over the past 4 weeks</i>, how do you rate your confidence that you could keep an erection?</p> <input type="checkbox"/> 1 Very Low
<input type="checkbox"/> 2 Low
<input type="checkbox"/> 3 Moderate
<input type="checkbox"/> 4 High
<input type="checkbox"/> 5 Very high | <p>4. <i>Over the past 4 weeks</i>, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?</p> <input type="checkbox"/> 1 Extremely difficult
<input type="checkbox"/> 2 Very difficult
<input type="checkbox"/> 3 Difficult
<input type="checkbox"/> 4 Slightly difficult
<input type="checkbox"/> 5 Not difficult |
| <p>2. <i>Over the past 4 weeks</i>, when you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?</p> <input type="checkbox"/> 1 Almost never or never
<input type="checkbox"/> 2 A few times (much less than half the time)
<input type="checkbox"/> 3 Sometimes (about half the time)
<input type="checkbox"/> 4 Most times (much more than half the time)
<input type="checkbox"/> 5 Almost always or always | <p>5. <i>Over the past 4 weeks</i>, when you attempted sexual intercourse how often was it satisfactory for you?</p> <input type="checkbox"/> 1 Almost never or never
<input type="checkbox"/> 2 A few times (much less than half the time)
<input type="checkbox"/> 3 Sometimes (about half the time)
<input type="checkbox"/> 4 Most times (much more than half the time)
<input type="checkbox"/> 5 Almost always or always |
| <p>3. <i>Over the past 4 weeks</i>, during sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?</p> <input type="checkbox"/> 1 Almost never or never
<input type="checkbox"/> 2 A few times (much less than half the time)
<input type="checkbox"/> 3 Sometimes (about half the time)
<input type="checkbox"/> 4 Most times (much more than half the time)
<input type="checkbox"/> 5 Almost always or always | <p>6. Which of the following best describes your sexual function? Circle the one answer that describes the BEST erectile function you have had over the past month, even if you used medication such as Cialis, Levitra or Viagra.</p> <input type="checkbox"/> 1 Normal, full erections
<input type="checkbox"/> 2 Full, but recently diminished
<input type="checkbox"/> 3 Partial, but satisfactory for intercourse
<input type="checkbox"/> 4 Partial, unsatisfactory for intercourse
<input type="checkbox"/> 5 Impotent, no erectile activity at all |

Do you have any other concerns regarding sexual function?
