METROVAN UROLOGY
metrovanurology.com
#650 – 6091 Gilbert Road
Richmond, B.C. V7C 5L9
Tel: **604 273 4320** (24 hrs)
Fax: 604 273 7599

International Prostate Symptom Score (IPSS/AUASS)

Last Name (REQUIRED) First Name (REQUIRED) PHN/CARE CARD NUMBER (REQUIRED)

Date

Instructions: These questions ask about your urinary symptoms, **OVER THE PAST 4 WEEKS**.
PLEASE COMPLETE BOTH SIDES OF THIS PAGE

CIRCLE/CLICK ONE NUMBER ON EACH LINE	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Incomplete Emptying 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. Frequency During 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. Intermittency During 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. Urgency During the past month or so, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
5. Weak Stream During the past month or so, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
6. Straining During the past month or so, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
	None	1 Time	2 Times	3 Times	4 Times	5 or More times
7. Nocturia Over the past month, how many times per night 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**	**1**	**2**	**3**	**4**	**5**

QUALITY OF LIFE

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

FOR OFFICE USE ONLY
Symptom Score: _____ / 35 (7/19/35) QOL: ____ / 6

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International Index of Erectile Function (IIEF-5/SHIM)

Instructions: These questions ask about the effects your erection problems have had on your sex life, **OVER THE PAST 6 MONTHS**. Please answer the following questions as honestly and clearly as possible. We understand the sensitive nature of these questions; therefore, all information is strictly confidential.

PLEASE COMPLETE BOTH SIDES OF THIS PAGE

Mark ONLY one circle per question:

1. Over the past 6 months, how do you rate your confidence that you could keep an erection?
   - ○ 1 Very Low
   - ○ 2 Low
   - ○ 3 Moderate
   - ○ 4 High
   - ○ 5 Very high

2. *Over the past 6 months*, when you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?
   - ○ 1 Almost never or never
   - ○ 2 A few times (much less than half the time)
   - ○ 3 Sometimes (about half the time)
   - ○ 4 Most times (much more than half the time)
   - ○ 5 Almost always or always

3. *Over the past 6 months*, during sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
   - ○ 1 Almost never or never
   - ○ 2 A few times (much less than half the time)
   - ○ 3 Sometimes (about half the time)
   - ○ 4 Most times (much more than half the time)
   - ○ 5 Almost always or always

4. *Over the past 6 months*, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
   - ○ 1 Extremely difficult
   - ○ 2 Very difficult
   - ○ 3 Difficult
   - ○ 4 Slightly difficult
   - ○ 5 Not difficult

5. *Over the past 6 months*, when you attempted sexual intercourse how often was it satisfactory for you?
   - ○ 1 Almost never or never
   - ○ 2 A few times (much less than half the time)
   - ○ 3 Sometimes (about half the time)
   - ○ 4 Most times (much more than half the time)
   - ○ 5 Almost always or always

FOR OFFICE USE ONLY

Score _____

Erectile Dysfunction	
5-7	Severe
8-11	Moderate
12-16	Mild-Mod
17-21	Mild
22-25	None

Men's Health Inventory

You only need to complete this section if you are a new patient or there have been changes since last seen.

Do you have a family history of prostate cancer?

☐ Yes ☐ No

If yes, please provide details if known (e.g. relation, age diagnosis, treatment)

Have you ever had any of the following? (check all that apply and provide details):

☐ Kidney stones ☐ Blood in the urine
☐ Bladder/kidney infection ☐ Surgery on the urinary tract
☐ Vasectomy

Thank you for completing this questionnaire. Email, Print, Fax or Bring to your appointment.