

TACKLING PROSTATE CANCER

Team Blue Iowa in partnership with the Urology Center Of Iowa, Quest Diagnostics and Hy-Vee

Personal Information:

Full legal name: _____
 Date of Birth: _____
 Race: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Email Address: _____
 Phone No.: _____ (home) _____ (mobile)
 Primary Care Physician: _____ Phone No.: _____

Clinical questions:

Family history of prostate cancer? Yes No if yes, who? _____
 Blood in the urine: Yes No

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?	0	1	2	3	4	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 you 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	

Would you be interested in treatment options?	Yes	No
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