Chicago Prostate Center

AUA Symptom Score
(Check 1 number on each line)

Patient Name: _____
Date of Birth: _____
Today's Date: _____

Questions to be Answered	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. Over the past month, 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, 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, how often have you found it difficult to postpone urination?	0☐	1☐	2☐	3☐	4☐	5☐
4. Over the past month, how often have you had a weak urinary stream?	0☐	1☐	2☐	3☐	4☐	5☐
5. Over the past month, how often have you had to push or strain to begin urination?	0☐	1☐	2☐	3☐	4☐	5☐
6. Over the past month, how often have you found you stopped and started again several times when you urinated?	0☐	1☐	2☐	3☐	4☐	5☐
Check the number of times that apply for the following question: 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?	☐ **none**	☐ **1 time**	☐ **2 times**	☐ **3 times**	☐ **4 times**	☐ **5 times**

Sum of 7 circled numbers (AUA Symptom Score):_____