CHICAGO PROSTATE CENTER

Patient Name:

Date of Birth:

EPIC

The Expanded Prostate Index Composite

This questionnaire is designed to measure Quality of Life issues in men. To help us get the most accurate measurement, it is important that you answer all questions honestly and completely.

Remember, as with all medical records, information contained within this survey will remain strictly confidential.

URINARY FUNCTION
This section is about your urinary habits. Please consider **ONLY THE LAST 4 WEEKS**.

1. Over the **past 4 weeks**, how often have you leaked urine?

(check one number)

More than once a day 1 ☐
About once a day 2 ☐
More than once a week 3 ☐
About once a week 4 ☐
Rarely or never 5 ☐

2. Over the **past 4 weeks**, how often have you urinated blood?

(check one number)

More than once a day 1 ☐
About once a day 2 ☐
More than once a week 3 ☐
About once a week 4 ☐
Rarely or never 5 ☐

3. Over the **past 4 weeks**, how often have you had pain or burning with urination?

(check one number)

More than once a day 1 ☐
About once a day 2 ☐
More than once a week. 3 ☐
About once a week 4 ☐
Rarely or never 5 ☐

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4. Which of the following best describes your urinary control **during the last 4 weeks?**

(check one number)

No urinary control whatsoever	..1	☐
Frequent dribbling	2	☐
Occasional dribbling	3	☐
Total control	4	☐

5. How many pads or adult diapers <u>per day</u> did you usually use to control leakage **during the last 4 weeks**?

(check one number)

None	0	☐
1 pad per day	1	☐
2 pads per day	2	☐
3 or more pads per day	3	☐

6. How big a problem, if any, has each of the following been for you **during the last 4 weeks**? ***(Check one number for each line)***

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem
a. Dripping urine or leaking urine	0☐	1☐	2☐	3☐	4☐
b. Pain or burning on urination	0☐	1☐	2☐	3☐	4☐
c. Bleeding with urination	0☐	1☐	2☐	3☐	4☐
d. Weak urine stream or incomplete emptying	0☐	1☐	2☐	3☐	4☐
e. Waking up to urinate	0☐	1☐	2☐	3☐	4☐
f. Need to urinate frequently during the day	0☐	1☐	2☐	3☐	4☐

7. Overall, how big a problem has your urinary function been for you **during the last 4 weeks**?

(check one number)

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

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BOWEL HABITS
The next section is about your bowel habits and abdominal pain.
Please consider **ONLY THE LAST 4 WEEKS**.

8. How often have you had rectal urgency (felt like I had to pass stool, but did not) **during the last 4 weeks**?

(check one number)

More than once a day	1 ☐
About once a day	2 ☐
More than once a week	3 ☐
About once a week	4 ☐
Rarely or never	5 ☐

9. How often have you had uncontrolled leakage of stool or feces?

(check one number)

More than once a day	1 ☐
About once a day	2 ☐
More than once a week	3 ☐
About once a week	4 ☐
Rarely or never	5 ☐

10. How often have you had stools (bowel movements) that were loose or liquid (no form, watery, mushy) **during the last 4 weeks**?

(check one number)

Never	1 ☐
Rarely	2 ☐
About half the time	3 ☐
Usually	4 ☐
Always	5 ☐

11. How often have you had bloody stools **during the last 4 weeks**?

(check one number)

Never	1 ☐
Rarely	2 ☐
About half the time	3 ☐
Usually	4 ☐
Always	5 ☐

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12. How often have your bowel movements been painful **during the last 4 weeks**?

Never	1 ☐

Rarely 2 ☐
(check one number) About half the time 3 ☐
Usually 4 ☐
Always 5 ☐

13. How many bowel movements have you had on a typical day **during the last 4 weeks**?
Two or less 1 ☐
(check one number) Three to four 2 ☐
Five or more 3 ☐

14. How often have you had crampy pain in your abdomen, pelvis or rectum **during the last 4 weeks**?
More than once a day 1 ☐
About once a day 2 ☐
(check one number) More than once a week 3 ☐
About once a week 4 ☐
Rarely or never 5 ☐

15. How big a problem, if any, has each of the following been for you **during the last 4 weeks**? ***(Check one number for each line)***

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem
a. Urgency to have a bowel movement	0☐	1☐	2☐	3☐	4☐
b. Increased frequency of bowel movements	0☐	1☐	2☐	3☐	4☐
c. Watery bowel movements	0☐	1☐	2☐	3☐	4☐
d. Losing control of your stools	0☐	1☐	2☐	3☐	4☐
e. Bloody stools	0☐	1☐	2☐	3☐	4☐
f. Abdominal/Pelvic/Rectal pain	0☐	1☐	2☐	3☐	4☐

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16. Overall, how big a problem have your bowel habits been for you **during the last 4 weeks**?
No problem 1 ☐
Very small problem 2 ☐
(check one number) Small problem 3 ☐

Moderate problem 4 ☐
Big problem 5 ☐

SEXUAL FUNCTION

The next section is about your **current** sexual function and sexual satisfaction. Many of the questions are very personal, but they will help us understand the important issues that you face every day. Remember, THIS SURVEY INFORMATION IS COMPLETELY **CONFIDENTIAL**. Please answer honestly about the **THE LAST 4 WEEKS ONLY**.

17. How would you rate each of the following **during the last 4 weeks**?
(Check one number on each line)

	Very Poor to None	Poor	Fair	Good	Very Good
a. Your level of sexual desire?	1☐	2☐	3☐	4☐	5☐
b. Your ability to have an erection?	1☐	2☐	3☐	4☐	5☐
c. Your ability to reach orgasm (climax)?	1☐	2☐	3☐	4☐	5☐

18. How would you describe the usual QUALITY of your erections **during the last 4 weeks**?

(check one number)

None at all 1 ☐
Not firm enough for any sexual activity…………… 2 ☐
Firm enough for masturbation and foreplay only. 3 ☐
Firm enough for intercourse 4 ☐

19. How would you describe the FREQUENCY of your erections?

(check one number)

I NEVER had an erection when I wanted one 1☐
I had an erection LESS THAN HALF the time I wanted one 2☐
I had an erection ABOUT HALF the time I wanted one 3☐
I had an erection MORE THAN HALF the time I wanted one 4☐
I had an erection WHENEVER I wanted one 5☐

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20. How often have you awakened in the morning or night with an erection **during the last 4 weeks**?

(check one number)

Never 1☐
Less than once a week 2☐
About once a week 3☐
Several times a week 4☐

Daily 5☐

21. **During the last 4 weeks**, how often did you have any sexual activity?

Not at all 1☐
Less than once a week 2☐
(check one number) About once a week 3☐
Several times a week 4☐
Daily 5☐

22. **During the last 4 weeks**, how often did you have sexual intercourse?

Not at all 1☐
Less than once a week 2☐
(check one number) About once a week 3☐
Several times a week 4☐
Daily 5☐

23. Overall, how would you rate your ability to function sexually **during the last 4 weeks**?

Very poor 1☐
Poor 2☐
(check one number) Fair 3☐
Good 4☐
Very good 5☐

24. How big a problem **during the last 4 weeks**, if any, has each of the following been for you? ***(Check one number for each line)***

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem
a. Your level of sexual desire	0☐	1☐	2☐	3☐	4☐
b. Your ability to have an erection	0☐	1☐	2☐	3☐	4☐
c. Your ability to reach an orgasm	0☐	1☐	2☐	3☐	4☐

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25. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks**?

No problem 1☐
Very small problem 2☐
(check one number) Small problem 3☐
Moderate problem 4☐
Big problem 5☐

THANK YOU FOR YOUR TIME AND COOPERATION.