

1. During the past month, please indicate how frequently you had these urinary symptoms and how large of a problem they were to you:	% OF TIME EXPERIENCED SYMPTOMS						HOW LARGE A PROBLEM?					1	
	0%	10%	25%	50%	75%	Almost 100%	None	Very Small	Small	Medium	Big		
Sensation of incomplete bladder emptying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	a	b
Having to urinate again after less than 2 hours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stopping and starting several times during urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Found it difficult to postpone urinating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weak urinary stream	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had to push or strain to begin urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. a. Over the past month, how many times per night did you typically get up to urinate?  
 0    1    2    3    4    5    6 or more times per night

b. How large of a problem was this to you?  
 None    Very small    Small    Medium    Big

3. Over the past month, how much physical discomfort did any urinary problems cause you?  
 None    Only a little    Some    A lot

4. Over the past month, how much did you worry about your health because of any urinary problems?  
 None    Only a little    Some    A lot

5. Overall, how bothersome has any trouble with urination been during the past month?  
 Not at all bothersome    Bothers me a little    Bothers me some    Bothers me a lot

6. Over the past month, how much of the time has any urinary problem kept you from doing the kinds of things you would usually do?  
 None of the time    A little of the time    Some of the time    Most of the time    All of the time

7. In general would you say your health is:    Excellent    Very good    Good    Fair    Poor

8. Since January 1, 1994, have you had screening for prostate cancer by using PSA (prostate specific antigen)?  
 Not known    No    Yes    If yes, what was the level?    Normal    Elevated

9. Since January 1, 1990, have you had an enlarged prostate detected by rectal exam?  
 No    Yes    If yes, year of diagnosis?    1990    1991    1992    1993    1994

10. Since January 1, 1990, has a physician told you that you have benign prostatic hyperplasia (BPH)?  
 No    Yes    If yes, year of diagnosis?    1990    1991    1992    1993    1994

11. Since January 1, 1990, have you had an episode of acute urinary retention requiring catheterization?  
 No    Yes    If yes, year of episode?    1990    1991    1992    1993    1994

12. Since January 1, 1990, have you had surgery for benign prostatic enlargement (prostate resection or TURP)?  
 No    Yes    If yes, year of surgery?    1990    1991    1992    1993    1994

13. During the past month, how often have your urinary problems interfered in the following activities? (Mark one response for each line.)

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time	13
Drinking fluids before you travel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	a
Drinking fluids before you go to bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	b
Driving for two hours without stopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	c
Getting enough sleep at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	d
Going to places that may not have a toilet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	e
Playing sports outdoors such as golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	f
Going to movies, shows, church, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	g

14. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of your time during the past 4 weeks . . . (Mark one response for each line.)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time	14
Did you feel full of pep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been a very nervous person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt so down in the dumps nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been a happy person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



15. Do you currently use the following medications regularly for prostate problems?

- Finasteride (PROSCAR)
- Alpha-blocker drugs (tetracosin-HYTRIN; prazosin-MINIPRESS; doxazosin-CARDURA)
- Other – Please specify \_\_\_\_\_

1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
4	4	4	4	4	4	4	4
8	8	8	8	8	8	8	8
P	P	P	P	P	P	P	P

ID

No regular medication

16. During the *past 4 weeks*, how much of the time have your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

17. Please choose the answer that best describes how true or false each of the following statements is for you. (Mark one response for each line.)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
Over the past 4 weeks, I have felt about the same as I have felt during the past year.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seem to get sick a little easier than other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am as healthy as anybody I know.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect my health to get worse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My health is excellent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any *emotional problems* (such as feeling depressed or anxious)? (Mark one response on each line.)

- a) Cut down the amount of time you spent on work or other activities  Yes  No
- b) Accomplished less than you would like  Yes  No
- c) Didn't do work or other activities as carefully as usual  Yes  No

19. During the *past 4 weeks*, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

20. How much *bodily pain* have you had during the *past 4 weeks*?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

21. During the *past 4 weeks*, how much did *bodily pain* interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

22. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your *physical health*?

- a) Cut down the amount of time you spent on work or other activities  Yes  No
- b) Accomplished less than you would like  Yes  No
- c) Were limited in the kind of work or other activities  Yes  No
- d) Had difficulty performing the work or other activities (for example, it took extra effort)  Yes  No

23. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Mark one response for each line.)

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All	0	1	2	3	4	5	6	7	8	9	10	11	12
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing <i>several</i> flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing <i>one</i> flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending, kneeling, or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <i>more than a mile</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <i>several blocks</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <i>one block</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please do not write in shaded area

24. Please WRITE in your date of birth:

MONTH	DAY	YEAR		

**Thank You Very Much!**