



International Prostate Symptom Score (IPSS)

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

Determine Your BPH Symptoms

Check your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one in 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?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Intermittency – How often have you found you stopped and started again several times when you urinated?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Urgency – How often have you found it difficult to postpone urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Weak stream – How often have you had a weak urinary stream?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Straining – How often have you had to push or strain to begin urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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?	None <input type="checkbox"/> 0	One Time <input type="checkbox"/> 1	Two Times <input type="checkbox"/> 2	Three Times <input type="checkbox"/> 3	Four Times <input type="checkbox"/> 4	Five or More Times <input type="checkbox"/> 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 your 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?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Have you tried medications to help your symptoms? Yes No

Did these medications help your symptoms?
 1 2 3 4 5 6 7 8 9 10

No relief

Complete Relief

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications? Yes No