PRINCETON Radiation Oncology

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# AUA SYMPTOM SCORE (AUASS)

**PATIENT NAME:** _____ **TODAY'S DATE:** _____

| (Circle One Number on Each Line) | Not at All | Less Than 1 Time in 5 | LessThan Half the Time | About Half the Time | More Than Half the Time | Almost Always |
|---|---|---|---|---|---|---|
| Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| During the past month or so, how often have you had to urinate again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| During the past month or so, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| During the past month or so, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| During the past month or so, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| During the past month or so, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| | None | 1 Time | 2 Times | 3 Times | 4 Times | 5 or More Times |
| Over the past month, how many times per night 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 the score for each number above and write the total in the space to the right.** **TOTAL:** _____

**SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)**

# QUALITY OF LIFE (QOL)

| | Delighted | Pleased | Mostly Satisfied | Mixed | Mostly Dissatisfied | Unhappy | Terrible |
|---|---|---|---|---|---|---|---|
| How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |