Radiotherapy Centers of Kentuckiana
a Vantage Oncology Affiliate

AUA Questionnaire on Urinary Function

First Name: _____ Last Name: _____

MRN #: _____ Date of Completion: _____

	In an effort to do a complete and accurate assessment of your urinary symptoms, we request you to please fill out this form. Please make a selection that best describes your situation.						
	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**	**Score**
Incomplete Emptying 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	
Frequency Over 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	
Intermittency Over the past month or so, how often have you stopped and started again several times when you urinated?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	
Urgency Over the past month or so, how often have you found it difficult to postpone urination?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	
Weak-stream Over the past month or so, how often have you had a weak urinary stream?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	
Straining Over 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 times or more**	
Nocturia 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?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	
						TOTAL:	____

☐ I acknowledge that I have reviewed and understand this document

Initials: _____ Date: _____

Radiotherapy Centers
OF KENTUCKIANA
a Vantage Oncology Affiliate

EPIC 26 - Short Version

First Name: _____ Last Name: _____

MRN #: _____ Date of Completion: _____

Instructions

This questionnaire is designed to measure Quality of Life issues in patients with Prostate cancer. 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.

If you have a urinary catheter, please start with Question 5.

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

More than once a day | About once a day | More than once a week | About once a week | Rarely or never

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

No urinary control whatsoever | Frequent dribbling | Occasional dribbling | Total control

3. How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?

None | 1 pad per day | 2 pads per day | 3 or more pads per day

4. How big a problem, if any, has each of the following been for you during the last 4 weeks?

	Symptom	No Problem (0)	Very Small Problem (1)	Small Problem (2)	Moderate Problem (3)	Big Problem (4)
A.	Dripping or leaking urine	○	○	○	○	○
B.	Pain or burning on urination	○	○	○	○	○
C.	Bleeding with urination	○	○	○	○	○
D.	Weak urine stream or incomplete emptying	○	○	○	○	○
E.	Waking up to urinate	○	○	○	○	○
F.	Need to urinate frequently during the day	○	○	○	○	○

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

No Problem | Very Small Problem | Small Problem | Moderate Problem | Big Problem

6.	How big a problem, if any, has each of the following been for you?					
	Symptom	**No Problem (0)**	**Very Small Problem (1)**	**Small Problem (2)**	**Moderate Problem (3)**	**Big Problem (4)**
A.	Urgency to have a bowel movement	◎	◎	◎	◎	◎
B.	Increased frequency of bowel movements	◎	◎	◎	◎	◎
C.	Losing control of your stools	◎	◎	◎	◎	◎
D.	Bloody stools	◎	◎	◎	◎	◎
E.	Abdominal/Pelvic/Rectal pain	◎	◎	◎	◎	◎

7.	Overall, how big a problem have your bowel habits been for you during the last 4 weeks?				
◎ No Problem	◎ Very Small Problem	◎ Small Problem	◎ Moderate Problem	◎ Big Problem	

8.	How would you rate each of the following during the last 4 weeks?					
	Symptom	**Very Poor to None (1)**	**Poor (2)**	**Fair (3)**	**Good (4)**	**Very Good (5)**
A.	Your ability to have an erection	◎	◎	◎	◎	◎
B.	Your ability to reach orgasm (climax)	◎	◎	◎	◎	◎

9.	How would you describe the usual QUALITY of your erections during the last 4 weeks?			
◎ None at all	◎ Not firm enough for sexual activity	◎ Firm enough for masturbation and foreplay only	◎ Firm enough for intercourse	

10.	How would you describe the FREQUENCY of your erections during the last 4 weeks?
1	◎ I NEVER had an erection when I wanted one
2	◎ I had an erection LESS THAN HALF the time I wanted one
3	◎ I had an erection ABOUT HALF the time I wanted one
4	◎ I had an erection MORE THAN HALF the time I wanted one
5	◎ I had an erection WHENEVER I wanted one

11.	Overall, how would you rate your ability to function sexually during the last 4 weeks?				
◎ Very Poor	◎ Poor	◎ Fair	◎ Good	◎ Very Good	

12.	Overall, how big a problem has your sexual function or lack of sexual function been for you during the last 4 weeks?				
◎ No Problem	◎ Very Small Problem	◎ Small Problem	◎ Moderate Problem	◎ Big Problem	

13.	How big a problem during the last 4 weeks, if any, has each of the following been for you?					
	Symptom	**No Problem (0)**	**Very Small Problem (1)**	**Small Problem (2)**	**Moderate Problem (3)**	**Big Problem (4)**
A.	Hot flashes	○	○	○	○	○
B.	Breast tenderness/enlargement	○	○	○	○	○
C.	Feeling depressed	○	○	○	○	○
D.	Lack of energy	○	○	○	○	○
E.	Change in body weight	○	○	○	○	○

During the **PAST 6 MONTHS**, have you used any devices, implants or medications REGULARLY to help with sexual function problems (such as vacuum suction device, penile injections(shots), Viagra, talking to a sex therapist or psychologist, penile implant or prosthesis)?

○ No
○ Yes

If so, please specify:

Please indicate how much it has helped:
○ Not at all
○ Somewhat
○ A lot

☐ I acknowledge that I have reviewed and understand this document

Initials: _____ Date: _____