ADVANCED RADIATION CENTERS of NEW YORK
A DIVISION OF INTEGRATED MEDICAL PROFESSIONALS

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AdvancedRadiationCenters.com

The largest experience in Volumetric Arc Radiation Therapy (RapidArc) and Image Guidance Radiation Therapy (IGRT) in Metropolitan New York

URINARY FUNCTION SCORING

URINARY SYMPTOM SCORING Check the number that appears BELOW the COLUMN HEADING DESCRIPTION	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	Your Score
Incomplete emptying In the past month on average, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
Frequency of urination In the past month on average, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5	
Intermittency In the past month on average, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency In past month on average, how often was it difficult to postpone urination?	0	1	2	3	4	5	
Weak stream In the past month on average, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining In the past month on average, how often did you push or strain to begin urination?	0	1	2	3	4	5	
Urination at nightime In the past month on average, how many times each night did you get up to urinate from when you went to bed until you woke in the morning?	0	1 time 1	2 times 2	3 times 3	4 times 4	5+times 5	

❑ 0-7: Mild Symptoms ❑ 8-19: Moderate Symptoms ❑ 20-35: Severe Symptoms

Total IPSS Score _____

PRIOR TO Radiation, were you taking any medications to help with urination?:
❑ No ❑ Yes: (check box) ❑ Flomax ❑ Uroxatral ❑ Hytrin ❑ Cardura ❑ Detrol ❑ Other:_____

DURING Radiation, were you prescribed taking any medications to help with urination?:
❑ No ❑ Yes: (check box) ❑ Flomax ❑ Uroxatral ❑ Hytrin ❑ Cardura ❑ Detrol ❑ Other:_____

CURRENTLY, are you taking any medications to help with urination?:
❑ No ❑ Yes: (check box) ❑ Flomax ❑ Uroxatral ❑ Hytrin ❑ Cardura ❑ Detrol ❑ Other:_____

Do you have PAIN when you urinate?
❑ NONE ❑ Mild ❑ Moderate Pain or I need medications for pain ❑ Severe pain ❑ Disabling pain

Do you have any URINARY LEAKAGE OR INCONTINENCE?:
❑ No ❑ Yes: (select one) ❑ minor post-stream dribbling, no pads required ❑ I use #_____ per day for leakage
❑ leakage interferes w/ my daily activities

Do you have any URINARY BLEEDING? ❑ No ❑ Yes: ❑ daily ❑ weekly

physician review _____

URINARY FUNCTION SCORING (con't)

HORMONE THERAPY USAGE: Did you get a Hormone INJECTION a few months before radiation?

❑ No ❑ Yes: (check box) If YES, answer the following:

What was the date of your FIRST ever hormone injection?:_____

How many months was the LAST injection supposed to last? (check one): ❑ 1 mo. ❑ 3 mos. ❑ 6 mos.

Are you scheduled to have another hormone injection? ❑ No ❑ Yes: (check box)

RECTAL SYMPTOMS

Do you have any RECTAL BLEEDING?:

❑ No ❑ Occasional, but no doctor intervention needed ❑ Yes, it required intervention or cauterization

If yes, did you have the same problem before Radiation? ❑ Yes ❑ No

Do you have any RECTAL PAIN?

❑ No ❑ Yes, mild ❑ Yes, interferes with my daily activities ❑ Yes, Loss of stool control

If yes, were you taking this also before Radiation? ❑ Yes ❑ No

How would you describe your Bowel Movements on average?

❑ Normal ❑ Occasional Diarrhea ❑ Constant Diarrhea ❑ Occasional Constipation ❑ Constant Constipation

❑ Alternating Diarrhea and Constipation

Are you taking any medication for Stool or Rectal pain?

❑ No ❑ Yes (check or write in): ❑ Immodium ❑ Lomotil ❑ Suppository ❑ Proctofoam ❑ Other:_____

ERECTILE FUNCTION SCORING

Are you sexually active now? ❑ Yes ❑ No ❑ No, because of the hormones I'm still taking

Are you taking any medication or aids for Erectile Dysfunction?

❑ Yes ❑ No (check or write in): ❑ Viagra ❑ Levitra ❑ Cialis ❑ Penile Implant ❑ Other:_____

Erectile Function Scoring *Over the past 6 months (or if you just finished radiation, based on the time since completing RT):*	*Check one answer per row following each question* **1**	**2**	**3**	**4**	**5**
How do you rate your confidence that you could get and keep an erection?	Very low	Low	Moderate	High	Very high
When you have erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never	**Much less than half the time**	**About half the time**	**Much more than half the time**	**Almost always or always**
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	**Much less than half the time**	**About half the time**	**Much more than half the time**	**Almost always or always**
During sexual intercourse how difficult is it to maintain an erection to the completion of intercourse?	Extremely difficult	**Very difficult**	**Difficult**	**Slightly difficult**	**Not difficult**
When you attempt sexual intercourse, how often was it satisfactory for you?	Almost never or never	**Much less than half the time**	**About half the time**	**Much more than half the time**	**Almost always or always**

TOTAL IIEF Score: _____

physician review _____