22224

The Expanded Prostate Cancer Index Composite -- RT

Date ☐☐ / ☐☐ / ☐☐☐☐

Official Use

MR# ☐☐☐☐☐☐

Last name _____

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.

BOWEL HABITS: Please make one choice. Please consider ONLY THE LAST 4 WEEKS.

1. How often have you had rectal urgency (felt like you had to pass a stool, but did not)?

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

2. How often have you had uncontrolled leakage of stool or feces?

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

3. How often have you had stools that were loose or liquid?

○ Never ○ Rarely ○ 1/2 the time ○ Usually ○ Always

4. How often have you had bloody stools?

○ Never ○ Rarely ○ 1/2 the time ○ Usually ○ Always

5. How often have your bowel movements been painful?

○ Never ○ Rarely ○ 1/2 the time ○ Usually ○ Always

6. How many bowel movements have you had on a typical day during the last 4 weeks?

○ 2 or less ○ 3 to 4 ○ 5 or more

7. How often have you had crampy pain in your abdomen, pelvis or rectum during the last 4 weeks?

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

8. How big a problem, if any, has each of the following been for you ? (select one response for each)

Problem:	None	Very small	Small	Moderate	Big problem
Urgency to have a bowel movement	○	○	○	○	○
Increased frequency of bowel movements	○	○	○	○	○
Watery bowel movements	○	○	○	○	○
Bloody stools	○	○	○	○	○
Losing control of your stools	○	○	○	○	○
Abdominal/Pelvic/Rectal pain	○	○	○	○	○
9. Overall, how big of a problem have your bowel habits been for you during the last 4 weeks?	○	○	○	○	○

10. Which therapy, if any, do you currently use to improve your erections?

Select one (*ONLY*)

○ None at all

○ Vacuum erection device (Erect-aid)

○ Penile injection therapy

○ Penile prosthesis

○ MUSE (intra-urethral alprostadil)

○ Viagra (Sildenafil)

○ Other _____

18917

INTERNATIONAL INDEX OF ERECTILE FUNCTION (IIEF-5)

Official Use:

Date ☐☐ / ☐☐ / ☐☐☐☐ MR#: ☐☐☐☐☐☐ **Last Name** _____

Please make ONE selection for each question.

	Very Low	Low	Moderate	High	Very High
1. How do you rate your confidence that you can get and keep an erection?	○ 1	○ 2	○ 3	○ 4	○ 5

	Not sexually active	Almost never/ Never	Rarely	Occasionally	Most of the time	Always
2. With sexual stimulation, how often have your erections been sufficient to allow for penetration (entering your partner)?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
3. During sexual intercourse, how often were you able to maintain an erection after penetration?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
	I haven't tried	**Extremely difficult**	**Very difficult**	**Difficult**	**Slightly difficult**	**Not difficult**
4. During sexual intercourse, how often has it been difficult to maintain your erections until the completion of intercourse?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
	Not sexually active	**Almost never/ Never**	**Rarely**	**Occassionally**	**Most of the time**	**Almost always/ Always**
5. When you attempt sexual intercourse, how often was it satisfactory for you?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

Please add the score for each number to determine the total score to the right. **TOTAL:** ☐☐

The IIEF - 5 score is the sum of questions 1-5. The lowest score is 5 and the highest is 25

39063

American Urological Association Symptom Score and Quality of Life

Date ☐☐ / ☐☐ / ☐☐☐☐

Official Use:
MR#: ☐☐☐☐☐☐

Last name _____

Mark ONE number on each line.	**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**
Over the past month or so, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
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
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 or so, how many times per night did you 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

	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