INTERNATIONAL PROSTATE SYMPTOM SCORE
(I-PSS)

DR SHILPA DAVÉ HEALTH
Personalised Lifestyle Medicine

Name: _____ **DOB:** _____ **Date:** _____

Please indicate the extent to which you have been bothered by any of the following symptoms **over the past month:**

	0 Not at all	1 Less than 1 in 5 times	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
1. Incomplete Emptying How often have you had a sensation of not emptying your bladder completely after you finish urinating?	☐	☐	☐	☐	☐	☐
2. Frequency How often have you had to urinate again less than two hours after you have finished urinating?	☐	☐	☐	☐	☐	☐
3. Intermittency How often have you found you stopped and started again several times when you urinated?	☐	☐	☐	☐	☐	☐
4. Urgency How often have you found it difficult to postpone urination?	☐	☐	☐	☐	☐	☐
5. Weak Stream How often have you had a weak urinary stream?	☐	☐	☐	☐	☐	☐
6. Straining How often have you had to push or strain to begin urination?	☐	☐	☐	☐	☐	☐

	None	Once	Twice	3 Times	4 Times	5 or More
7. Nocturia How many times did you most typically get up each night to urinate, from the time you went to bed until the time you got up in the morning?	☐	☐	☐	☐	☐	☐
(for internal use) **TOTAL I-PSS SCORE:**						

	0 Delighted	1 Pleased	2 Mostly Satisfied	3 Mixed	4 Mostly Unhappy	5 Unhappy	6 Terrible
Quality of life due to symptoms: How would you feel if you had to spend the rest of your life with your urinary condition just the way it is now?	☐	☐	☐	☐	☐	☐	☐

Please return your completed form to pa@privategp.org or bring it with you when you attend your appointment.