

AUA Form

Your Name: _____

ROBOTIC # _____

Date: _____

I have used:

Yes No **Viagra**
 Yes No **Other:** _____

Please answer the following questions of urinary symptoms and potency for the period of time on the last 30 days. Please circle the appropriate answer. If you have used any aids for erectile dysfunction (i.e. Viagra, etc.) then use additional XXs to mark the correct potency answer for the erectile aid.

Urinary Symptoms

Key:

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
0	1	2	3	4	5

Please circle the answer that best describes your response to each of the following questions:

1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?

0	1	2	3	4	5
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2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?

0	1	2	3	4	5
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3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?

0	1	2	3	4	5
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4. Urgency Over the past month, how often have you found it difficult to postpone urination?

0	1	2	3	4	5
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5. Weak stream Over the past month, how often have you had a weak urinary stream?

0	1	2	3	4	5
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6. Straining Over the past month, how often have you had to push or strain to begin urination?

0	1	2	3	4	5
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7. 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 times	1 time	2 times	3 times	4 times	5 + times
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Score _____ (Office Use only)

*** Quality of Life Due to Urinary Symptoms**

If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about it?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	1	2	3	4	5	6

Potency

Each question has several possible responses. Please circle the number of the response that best describes your own situation. Make sure that you select only one response for each question.

Over the past six months:

1. How do you rate your confidence that you could get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost Always or always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not Attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not Attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory to you?

Did not Attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

Score _____ (Office Use Only)

Do you have Erections Satisfactory for Penetration?

Yes No