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**AUA SCORE SHEET**

Name: \_\_\_\_\_ Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

	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
<b>1. Incomplete emptying:</b> How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
<b>2. Frequency:</b> How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
<b>3. Intermittency:</b> How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>4. Urgency:</b> How often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>5. Weak Stream:</b> How often have you had a weak urinary stream?	0	1	2	3	4	5
<b>6. Straining:</b> How often have you had to push or strain with urination?	0	1	2	3	4	5
<b>7. Nocturia:</b> How many times do you most typically get up to urinate from the time you go to bed until the time you get up in the morning?	None	1 time	2 times	3 times	4 times	5 or more times
<b>Total Score</b>						

**Quality of life due to urinary symptoms:**

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

- \_\_\_\_\_ 0. Delighted
- \_\_\_\_\_ 1. Pleased
- \_\_\_\_\_ 2. Mostly satisfied
- \_\_\_\_\_ 3. Mixed – about equally satisfied and dissatisfied
- \_\_\_\_\_ 4. Mostly dissatisfied
- \_\_\_\_\_ 5. Unhappy
- \_\_\_\_\_ 6. Terrible

**Urine: \_\_\_\_\_ Regular \_\_\_\_\_ Uroflow**  
(For office use only)