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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased frequency of bowel movements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watery bowel movements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloody stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Losing control of your stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal/Pelvic/Rectal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Overall, how big of a problem have your bowel habits been for you during the last 4 weeks?  
 None    Very small    Small    Moderate    Big problem
10. Which therapy, if any, do you currently use to improve your erections?  
 None at all  
 Vacuum erection device (Erect-aid)  
 Penile injection therapy  
 Penile prosthesis  
 MUSE (intra-urethral alprostadil)  
 Viagra (Sildenafil)  
 Other \_\_\_\_\_

**Select one (ONLY)**

**Please make ONE selection for each question.**

	<u>Very Low</u>	<u>Low</u>	<u>Moderate</u>	<u>High</u>	<u>Very High</u>
1. How do you rate your confidence that you can get and keep an erection?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

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

<b>Mark ONE number on each line.</b>	<b><u>Not at All</u></b>	<b><u>Less than 1 time in 5</u></b>	<b><u>Less than Half the time</u></b>	<b><u>About Half the time</u></b>	<b><u>More than Half the time</u></b>	<b><u>Almost always</u></b>
Over the past month or so, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
During the past month or so, how often have you found it difficult to postpone urination?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
During the past month or so, how often have you had a weak urinary stream?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
During the past month or so, how often have you had to push or strain to begin urination?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	<b><u>None</u></b>	<b><u>1 time</u></b>	<b><u>2 times</u></b>	<b><u>3 times</u></b>	<b><u>4 times</u></b>	<b><u>5 or more times</u></b>
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?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

	<b><u>Delighted</u></b>	<b><u>Pleased</u></b>	<b><u>Mostly Satisfied</u></b>	<b><u>Mixed</u></b>	<b><u>Mostly Dissatisfied</u></b>	<b><u>Unhappy</u></b>	<b><u>Terrible</u></b>
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?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6