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Patient name: ***Date:***

Diarrhea	None	Rare	Some	Quite a bit	Severe
Constipation	None	Rare	Some	Quite a bit	Severe
Loss of Appetite	None	Rare	Some	Quite a bit	Severe
Dryness of Mouth	None	Rare	Some	Quite a bit	Severe
Runny Nose	None	Rare	Some	Quite a bit	Severe
Itching	None	Rare	Some	Quite a bit	Severe
Dizziness	None	Rare	Some	Quite a bit	Severe
Weakness	None	Rare	Some	Quite a bit	Severe
Change of Vision	None	Rare	Some	Quite a bit	Severe
Sleeplessness	None	Rare	Some	Quite a bit	Severe
Palpitations	None	Rare	Some	Quite a bit	Severe
Nervousness/Tension	None	Rare	Some	Quite a bit	Severe
Depression	None	Rare	Some	Quite a bit	Severe
Headaches	None	Rare	Some	Quite a bit	Severe
Backaches	None	Rare	Some	Quite a bit	Severe

PLEASE PRINT YOUR NAME AT THE TOP OF THIS PAGE. PLEASE FLIP OVER AND FILL OUT OTHER SIDE ALSO. THANK YOU!

Lower Abdominal Pressure ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Lower Abdominal Pain ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Painful Intercourse ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Vaginal Pressure ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Vaginal Discharge ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Bleeding ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Burning when urinating ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Uncomfortable strong need to pass urine ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Sensation of continued need to urinate ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Loss of urine when coughing or straining ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Loss of urine before reaching toilet ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Involuntary loss of stool ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

Involuntary loss of gas ○ None ○ Rare ○ Some ○ Quite a bit ○ Severe

How many hours between times you urinate ○ <1 ○ 1 ○ 2 ○ 3 ○ 4

The # of times you urinate after going to sleep ○ 0 ○ 1 ○ 2 ○ 3 ○ 4

The # of times you urinate during the first hour of sleep ○ 0 ○ 1 ○ 2 ○ 3 ○ 4