

***Patient name:***

***Date:***

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

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

<b>Lower Abdominal Pressure</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Lower Abdominal Pain</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Painful Intercourse</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Vaginal Pressure</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Vaginal Discharge</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Bleeding</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Burning when urinating</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Uncomfortable strong need to pass urine</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Sensation of continued need to urinate</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Loss of urine when coughing or straining</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Loss of urine before reaching toilet</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Involuntary loss of stool</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>Involuntary loss of gas</b>	<input type="radio"/> None	<input type="radio"/> Rare	<input type="radio"/> Some	<input type="radio"/> Quite a bit	<input type="radio"/> Severe
<b>How many hours between times you urinate</b>	<input type="radio"/> <1	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
<b>The # of times you urinate after going to sleep</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
<b>The # of times you urinate during the first hour of sleep</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4