

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!

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