FORM TITLE: EPIC Quality of Life Questionnaire for Patient

Case #: _____ Name (optional): _____Date: ____MM/____DD/_____YY

Instructions: Please answer the following questions

URINARY FUNCTION
This section is about your urinary habits. Please consider **ONLY THE LAST 4 WEEKS.**

1.) Over the PAST 4 WEEKS, how often have you leaked urine? (Circle one number)

More than once a day	**1**
About once a day	**2**
More than once a week	**3**
About once a week	**4**
Rarely or never	**5**

2.) Which of the following best describes your urinary control DURING THE LAST 4 WEEKS? (Circle one number)

No urinary control whatsoever	**1**
Frequent dribbling	**2**
Occasional dribbling	**3**
Total control	**4**

3.) How many pads or adult diapers per day did you usually use to control leakage DURING THE LAST 4 WEEKS? (Circle one number)

None	**0**
1 pad per day	**1**
2 pads per day	**2**
3 or more pads per day	**3**

4.) How big a problem, if any, has each of the following been for you DURING THE LAST 4 WEEKS? (Circle one number on each line)

	No Problem	Very Small Problem	Small Problem	Moderate Problem	Big Problem
a.) Dripping or leaking urine……..	**0**	**1**	**2**	**3**	**4**
b.) Pain or burning in urination….	**0**	**1**	**2**	**3**	**4**
c.) Bleeding with urination……..	**0**	**1**	**2**	**3**	**4**
d.) Weak urine stream or incomplete emptying	**0**	**1**	**2**	**3**	**4**
e.) Need to urinate frequently during the day	**0**	**1**	**2**	**3**	**4**

5.) Overall, how big a problem has your urinary function been for you DURING THE PAST 4 WEEKS? (Circle one number)

No problem	**1**
Very small problem	**2**
Small problem	**3**
Moderate problem	**4**
Big problem	**5**

BOWEL HABITS: This section is about your bowel habits and abdominal pain. Please consider **ONLY THE LAST 4 WEEKS.**

6.) How big a problem, if any, has each of the following been for you? (Circle one number on each line).

	No Problem	**Very Small Problem**	**Small Problem**	**Moderate Problem**	**Big Problem**
a.) Urgency to have a bowel movement……	**0**	**1**	**2**	**3**	**4**
b.) Increased frequency of bowel movements……	**0**	**1**	**2**	**3**	**4**
c.) Losing control of your stools….	**0**	**1**	**2**	**3**	**4**
d.) Bloody stools……	**0**	**1**	**2**	**3**	**4**
e.) Abdominal/Pelvic/Rectal pain…	**0**	**1**	**2**	**3**	**4**

7.) Overall, how big a problem have your bowel habits been for you DURING THE LAST 4 WEEKS? (Circle one number)

No problem	**1**
Very small problem	**2**
Small problem	**3**
Moderate problem	**4**
Big problem	**5**

SEXUAL FUNCTION: This section is about your **current** sexual function and sexual satisfaction. Many of the questions are very personal, but they will help us understand the important issues that you face every day. Remember, THIS SURVEY INFORMATION IS COMPLETELY **CONFIDENTIAL**. Please answer honestly about **THE LAST 4 WEEKS ONLY.**

8.) How would you rate each of the following DURING THE PAST 4 WEEKS?
(Circle one number on each line)

	Very Poor to None	**Poor**	**Fair**	**Good**	**Very Good**
a.) Your ability to have an erection?.....	**1**	**2**	**3**	**4**	**5**
b.) Your ability to reach orgasm (climax)?	**1**	**2**	**3**	**4**	**5**

9.) How would you describe the usual QUALITY of your erections DURING THE LAST 4 WEEKS? (Circle one number)

None at all	**1**
Not firm enough for any sexual activity	**2**
Firm enough for masturbation and foreplay only	**3**
Firm enough for intercourse	**4**

10.) How would you describe the FREQUENCY of your erections DURING THE LAST 4 WEEKS? (Circle one number)

I NEVER had an erection when I wanted one	**1**
I had an erection LESS THAN HALF of the time I wanted one	**2**
I had an erection ABOUT HALF the time I wanted one	**3**
I had an erection MORE THAN HALF of the time I wanted one	**4**
I had an erection WHENEVER I wanted one	**5**

11.) Overall, how would you rate your ability to function sexually DURING THE LAST 4 WEEKS? (Circle one number)

Very poor	**1**
Poor	**2**
Fair	**3**
Good	**4**
Very good	**5**

12.) Overall, how big a problem has your sexual function or lack of sexual function been for you DURING THE LAST 4 WEEKS? (Circle one number)

No problem	**1**
Very small problem	**2**
Small problem	**3**
Moderate problem	**4**
Big problem	**5**

13.) How big a problem DURING THE LAST 4 WEEKS, if any, has each of the following been for you? (Circle one number on each line)

	No Problem	**Very Small Problem**	**Small Problem**	**Moderate Problem**	**Big Problem**
a.) Hot flashes…….……...	**0**	**1**	**2**	**3**	**4**
b.) Breast tenderness/enlargement	**0**	**1**	**2**	**3**	**4**
c.) Feeling depressed…….…….…..	**0**	**1**	**2**	**3**	**4**
d.) Lack of energy……..…….....	**0**	**1**	**2**	**3**	**4**
e.) Change in body weight……	**0**	**1**	**2**	**3**	**4**

THANK YOU FOR YOUR PARTICIPATION!