

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas:

- |   | Yes                     | No                      |
|---|-------------------------|-------------------------|
| a. Areas between rectum and testicles (perineum)    | <input type="radio"/> 1 | <input type="radio"/> 0 |
| b. Testicles  | <input type="radio"/> 1 | <input type="radio"/> 0 |
| c. Tip of the penis (not related to urination)      | <input type="radio"/> 1 | <input type="radio"/> 0 |
| d. Below your waist (in your pubic or bladder area) | <input type="radio"/> 1 | <input type="radio"/> 0 |

2. In the last week, have you experienced:

- |   |                         |                         |
|---|-------------------------|-------------------------|
| a. Pain or burning during urination               | <input type="radio"/> 1 | <input type="radio"/> 0 |
| b. Pain or discomfort during or after ejaculation | <input type="radio"/> 1 | <input type="radio"/> 0 |

3. How often have you had pain or discomfort in any of these areas over the last week?

- 0 Never
- 1 Rarely
- 2 Sometimes
- 3 Often
- 4 Usually
- 5 Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you have had it over the last week?

- |                         |                         |                         |                         |                         |                         |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|

(No Pain)

- |                         |                         |                         |                         |   |
|-------------------------|-------------------------|-------------------------|-------------------------|---|
| <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10 (Extreme Pain) |
|-------------------------|-------------------------|-------------------------|-------------------------|---|

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- 0 Not at all
- 1 Less than 1 time in 5
- 2 Less than half the time
- 3 About half the time
- 4 More than half the time
- 5 Almost always

6. How often have you had to urinate less than two hours after you finished urinating, over the last week?

- 0 Not at all
- 1 Less than 1 time in 5
- 2 Less than half the time
- 3 About half the time
- 4 More than half the time
- 5 Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- 0 None
- 1 Only a little
- 2 Some
- 3 A lot

8. How much did you think about your symptoms, over the last week?

- 0 None
- 1 Only a little
- 2 Some
- 3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about it?

- 0 Delighted
- 1 Please
- 2 Mostly satisfied
- 3 Mixed (about equally satisfied and dissatisfied)
- 4 Mostly dissatisfied
- 5 unhappy
- 6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3 and 4 \_\_\_\_\_

Urinary Symptoms: Total of items 5 and 6 \_\_\_\_\_

Quality of Life Impact: Total of items 7, 8 and 9 \_\_\_\_\_