PLEASE COMPLETE THIS QUESTIONNAIRE FOR THE **PAST MONTH**

MALE HEALTH INVENTORY

Name .....
Date of birth .....
Date .....
Current PSA level .....

These questions are designed to help you and your doctor identify whether you may be experiencing **erectile dysfunction**, also known as **impotence**. If you are, and your treatment worsens the condition, you may wish to discuss the treatment options with your doctor.

Circle the response that best describes your own situation. Please be sure that you select one and only one response for each question.

1. Could you get an erection sufficient for intercourse? **Yes** **No**
2. Are you currently taking Viagra, Levitra or Cialis? **Yes** **No**
3. Over the past month, how do you rate your confidence that you can get and keep your erection?

Very low	Low	Moderate	High	Very high
1	2	3	4	5

4. Over the past month, when you had erections with sexual stimulation, ***how often*** were your erections hard enough for penetration?

No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

5. Over the past month, during sexual intercourse, ***how often*** were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

6. Over the past month, during sexual intercourse, ***how difficult*** was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

7. Over the past month, when you attempted sexual intercourse, ***how often*** was it satisfactory for you?

Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

These questions relate to your current **ease of urination** and are **of great importance** in assessing you for Brachytherapy and for your follow-up. Please circle the closest answer to how you have felt over the last month.

1. **Incomplete Emptying** Over the past month, ***how often*** have you had a sensation of not emptying your bladder completely after you finish urinating?

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

2. **Frequency** Over the past month, ***how often*** have you had to urinate again less than 2 hours after you finished urinating?

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

3. **Intermittency** Over the past month, ***how often*** have you found you had stopped and started again several times when you urinated?

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

4. **Urgency** Over the past month, ***how often*** have you found it difficult to postpone urination?

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

5. **Weak Stream** Over the past month, ***how often*** have you had a weak urinary stream?

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

6. **Straining** Over the past month, ***how often*** have you had to push or strain to begin urination?

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

7. **Nocturia** Over the past month, ***how many times*** on average did you get up each night to urinate?

None	1 time	2 times	3 times	4 times	5 times or more
0	1	2	3	4	5

Quality of Life due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition just the way it is now, ***how would you feel*** about that?

Delighted	Pleased	Mostly satisfied	Mixed (Equally satisfied & dissatisfied)	Mostly dissatisfied	Unhappy	Terrible
0	1	2	3	4	5	6

These questions relate to your **bowel function**.

1. Have your daily activities been limited by your bowel problems?

Not at all	A little	Quite a bit	Very much
1	2	3	4

2. Have you had any unintentional release (leakage) of stools?

Not at all	A little	Quite a bit	Very much
1	2	3	4

3. Have you had blood in your stools?

Not at all	A little	Quite a bit	Very much
1	2	3	4

4. Did you have a bloated feeling in your abdomen?

Not at all	A little	Quite a bit	Very much
1	2	3	4

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Thank you for completing this questionnaire