BASELINE SURVEY

Please complete prior to surgery

Please complete the attached survey.

Print your name, sign, and date below. Thank you.

Patient Name (print): _____

Patient Signature: _____

Date completed (MM/DD/YYYY): _____

The following questions pertain to your current state of health and relationship status.

1. Using the scale below, circle one number that indicates how you feel about your current state of health.

0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Very Poor					**Average**					**Excellent**

2. Please select one response, which best describes you:

- ☐ Married
- ☐ In a committed relationship
- ☐ Dating
- ☐ Divorced
- ☐ Widowed
- ☐ Single

This questionnaire is designed to measure Quality of Life issues in patients with Prostate cancer. To help us get the most accurate measurement, it is important that you answer all questions honestly and completely.

Questions regarding sexual function, activities, and erectile use include all forms of sexual activity in the PAST 4 WEEKS.

Remember, as with all medical records, information contained within this survey will remain strictly confidential.

1. Over the **past 4 weeks**, how often have you leaked urine?
   - ☐ More than once a day
   - ☐ About once a day
   - ☐ More than once a week
   - ☐ About once a week
   - ☐ Rarely or never

2. Which of the following best describes your urinary control **during the last 4 weeks**?
   - ☐ No urinary control whatsoever
   - ☐ Frequent dribbling
   - ☐ Occasional dribbling
   - ☐ Total control

3. How many pads or adult diapers per day did you usually use to control leakage **during the last 4 weeks**?
   - ☐ None
   - ☐ 1 pad per day
   - ☐ 2 pads per day
   - ☐ 3 or more pads per day

4. How big a problem, if any, has each of the following been for you **during the last 4 weeks**?

	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 on 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 last 4 weeks**?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Moderate problem
- ☐ Big problem

6. How big a problem, if any, has each of the following been for you?

		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**?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Moderate problem
- ☐ Big problem

8. How would you rate each of the following **during the last 4 weeks**?

	Very Poor to None	Poor	Fair	Good	Very Good
a. Your ability to have an erection?	0	1	2	3	4
b. Your ability to reach orgasm (climax)?	0	1	2	3	4

9. How would you describe the usual QUALITY of your erections **during the last 4 weeks**?

- ☐ None at all
- ☐ Not firm enough for any sexual activity
- ☐ Firm enough for masturbation and foreplay only
- ☐ Firm enough for intercourse

10. How would you describe the FREQUENCY of your erections **during the last 4 weeks**?

- ☐ I NEVER had an erection when I wanted one
- ☐ I had an erection LESS THAN HALF the time I wanted one
- ☐ I had an erection ABOUT HALF the time I wanted one
- ☐ I had an erection MORE THAN HALF the time I wanted one
- ☐ I had an erection WHENEVER I wanted one

11. Overall, how would you rate your ability to function sexually **during the last 4 weeks**?

- ☐ Very poor
- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very good

12. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks**?

- ☐ No problem
- ☐ Very small problem
- ☐ Small problem
- ☐ Moderate problem
- ☐ Big problem

13. How big a problem **during the last 4 weeks**, if any, has each of the following been for you?

		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

The following questions pertain to your sexual activity and use of erectile aids.

1. In the PAST 4 WEEKS, how interested have you been in sexual activity?
   - ☐ Not at all
   - ☐ A little bit
   - ☐ Somewhat
   - ☐ Quite a bit
   - ☐ Very much

2. In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?
   - ☐ 0 times (If selected, skip to question 6)
   - ☐ 1 time
   - ☐ 2 times
   - ☐ 3 times
   - ☐ 4 or more times

3. When you have had a sexual activity, how satisfying has it been?
   - ☐ Not at all
   - ☐ A little bit
   - ☐ Somewhat
   - ☐ Quite a bit
   - ☐ Very much

4. Please select the erectile aids you may have used in the PAST 4 WEEKS for sexual activity. Please choose all that apply.
   - ☐ None
   - ☐ Pills (Viagra, Cialis, Levitra, Stendra, Sildenafil, Staxyn)
   - ☐ Urethral Suppository (MUSE)
   - ☐ Penile Injection
   - ☐ Vacuum Erection Device
   - ☐ Other (specify):_____

5. When you have been sexually active over the PAST 4 WEEKS, did you use erectile aids:

- ☐ Almost never/never
- ☐ A few times (less than half of the time)
- ☐ Sometimes (about half of the time)
- ☐ Most Times (more than half o f the time)
- ☐ Almost always/always

6. Why have you not been sexually active? Please choose all that apply.

- ☐ Lack of a willing partner
- ☐ Lack of interest
- ☐ Lack of confidence
- ☐ No ejaculate
- ☐ No erection
- ☐ Urine leak during intercourse
- ☐ Pain/discomfort during intercourse
- ☐ Other (specify):_____

The following questions are regarding your pain management in the last year

1. Have you taken opioid/narcotic medications in the past year? (e.g. Tylenol-3, Vicodin, Oxycodone, etc.)

   ☐ Yes

   ☐ No

2. Please rate your pain by selecting the one number that best describes you pain at its ***WORST*** in the last week:

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Pain as Bad as You Can Imagine**

3. Please rate your pain by selecting the one number that best describes your pain at its ***AVERAGE*** in the last week:

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Pain as Bad as You Can Imagine**

The following questions pertain to your smoking history.

1. In the PAST 30 DAYS, have you smoked cigarettes?
   - ☐ Yes (If yes, go to question 1a)
   - ☐ No (If no, skip to question 2)

   1a. How many cigarettes a day do you smoke? _____

   1b. Since your prostate cancer diagnosis, did a doctor or other healthcare worker talk to you about quitting cigarettes?
   - ☐ Yes
   - ☐ No

   1c. Would you like resources regarding smoking cessation?
   - ☐ Yes (If yes, go to 1d)
   - ☐ No (If no, STOP)

   1d. Michigan Quit Line: 1-800-QUITNOW (1-800-784-8669)
   www.michigan.gov/tobacco

2. Have you ever smoked?
   - ☐ Yes (If yes, go to question 2a)
   - ☐ No (If no, STOP)

   2a. If yes, when did you stop? _____ (MM/YYYY)

   2b. If yes, how many cigarettes did you smoke a day on average? _____

Thank you.