



## Patient-Reported Outcomes Measurement Information System (PROMIS)

The following questions are from the Patient-Reported Outcomes Measurement Information System (PROMIS) and are designed to assess your health status. Your responses will help your doctor better understand your current symptoms and how to provide the best urinary stone care for you. Please answered the following questions to how you felt IN THE PAST 7 DAYS



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*[Place Patient's Label Here]*

	Had no pain	Mild	Moderate	Severe	Very severe
1. How intense was your pain at its worst?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How intense was your average pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. What is your pain right now?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not at all	A little bit	Somewhat	Quite a bit	Very Much
4. How much did pain interfere with your enjoyment of life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How much did pain interfere with your ability to concentrate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How much did pain interfere with your day to day activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How much did pain interfere with your enjoyment of recreational activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How much did pain interfere with your tasks away from home (e.g. getting groceries, running errands)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never	Rarely	Sometimes	Often	Always
9. How often did pain keep you from socializing with others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**LURN SYMPTOM INDEX-10 (LURN SI-10)**

**Instruction: This questionnaire asks you about different urinary symptoms. Please read each question carefully, and then circle the response that best describes your symptoms.**

	<i>Never</i>	<i>A few times</i>	<i>About half the time</i>	<i>Most of the time</i>	<i>Every time</i>
1. In the past 7 days, how often did you feel a sudden need to urinate?	0	1	2	3	4
2. In the past 7 days, how often did you leak urine or wet a pad after feeling a sudden need to urinate?	0	1	2	3	4
3. In the past 7 days, how often did you leak urine or wet a pad while laughing, sneezing, or coughing?	0	1	2	3	4
4. In the past 7 days, how often did you leak urine or wet a pad when doing physical activities, such as exercising or lifting a heavy object?	0	1	2	3	4
5. In the past 7 days, how often did you have pain or discomfort in your bladder while it was filling?	0	1	2	3	4
6. In the past 7 days, how often did you have a delay before you started to urinate?	0	1	2	3	4
7. In the past 7 days, how often was your urine flow slow or weak?	0	1	2	3	4
8. In the past 7 days, how often did you dribble urine just after zipping your pants or pulling up your underwear?	0	1	2	3	4
<b>Circle number here --&gt;</b>	0	1	2	3	
9. In the past 7 days, during waking hours, how many times did you typically urinate?	(3 or fewer times a day)	(4-7 times a day)	(8-10 times a day)	(11 or more times a day)	
<b>Circle number here --&gt;</b>	0	1	2	3	
10. In the past 7 days, during a typical night, how many times did you wake up and urinate?	(none)	(1 time)	(2-3 times)	(More than 3 times)	