

## 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





[Place Patient's Label Here]

		Had no pain	Mild	Moderate	Severe	Very severe
1.	How intense was your pain at its worst?	0	0	0	0	0
2.	How intense was your average pain?	0	0	0	0	0
3.	What is your pain right now?	0	0	0	0	0
4	How much did pain interfere with your	Not at all	A little bit	Somewhat	Quite a bit	Very Much
7,	enjoyment of life?		0	0	O	0
5.	How much did pain interfere with your ability to concentrate?	0	0	0	0	0
6.	How much did pain interfere with your day to day activities?	0	0	0	0	0
7.	How much did pain interfere with your enjoyment of recreational activities?	0	0	0	0	0
8.	How much did pain interfere with your tasks away from home (e.g. getting groceries, running errands)?	0	0	0	0	0
9.	How often did pain keep you from socializing with others?	Never	Rarely	Sometimes	Often	Always



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

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

• ,,							
		Never	A few times	About half	Most of	Every time	
1. In the past 7 days, how ofte to urinate?	en did you feel a sudden need	0	1	2	3	4	
2. In the past 7 days, how ofte pad after feeling a sudden nee		0	1	2	3	4	
3. In the past 7 days, how ofte pad while laughing, sneezing,		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 ofte weak?	0	1	2	3	4		
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	
	Circle number here>	0	1	2	,	3	
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)		
	Circle number here>	0	1	2	,	3	
10. In the past 7 days, during times did you wake up and uri	(none)	(1 time)	(2-3 times)	(More tha	n 3 times)		



## ICIQ-S

## **CONFIDENTIAL**

Answer the following questions thinking about how satisfied you were with the treatment or surgery that you had. All the information you give us is confidential.

1.	How would you rate the outcome of your surgery?	
	very successful	4
	somewhat successful	3
	neither successful nor unsuccessful	2
	a little unsuccessful	1
	very unsuccessful	0
	vory dribubbbbliding	
2	Compared to how you felt before your ourgon, how is your condition new?	
2.	Compared to how you felt before your surgery, how is your condition now?	
	much better	4
	a bit better	3
	about the same	2
	a bit worse	1
	much worse	0
3.	Would you say you have been able to return to a 'normal life' after your surgery?	
	otrongly agree (or Lyga not limited before)	3
	strongly agree (or I was not limited before)	2
	agree	1
	disagree	0
	strongly disagree	

4.	If you were in the same situation again, would you still have the surgery?
	yes, definitely 4  yes, probably 3  not sure 2  no, probably not 1  no, definitely not 0
5.	Would you recommend this surgery to friends or relatives with similar problems?
	yes, definitely 4  yes, probably 3  not sure 2  no, probably not 1  no, definitely not 0
6.	If you had to spend the rest of your life with your symptoms as they are now, how would
	perfectly happy (or I no longer have any symptoms)  somewhat happy  mixed feelings  somewhat unhappy  very unhappy  desperate  0
	Outcome score: sum scores items 1-6
	USSQ question concerning stent

Instruction: Answer the question below if you had a stent placed during the surgical procedure otherwise select N/A.

	Delighted	Pleased	Mostly	Mixed	Mostly	Unhappy	Terrible	Not
			Satisfied	Feelings	Dissatisfied			Applicable (N/A)
In the future, if I were advised to have another stent inserted, how would I feel about it?								