PELVIC PAIN SYMPTOM SCORE
MALE

Name _____ Date _____

Over the past month or so, including today, how much were you bothered by:

	Not at All	A little Bit	Moderately	Quite a Bit	Extreme
Pain in the lower back	0	1	2	3	4
Pain in the lower abdomen/pubic area	0	1	2	3	4
Pain during urination	0	1	2	3	4
Pain with bowel movements	0	1	2	3	4
Pain in the rectum	0	1	2	3	4
Pain in the prostate gland	0	1	2	3	4
Pain in the testicles	0	1	2	3	4
Pain in the penis	0	1	2	3	4
Number of days experienced pain in the last month	0	6	15	24	30
How bad is the pain on average now	0----------				----------10
				Total Pain Score_____	
Difficulty postponing urination, hard to hold it (urgency)	0	1	2	3	4
Need to urinate again less than 2 hours after urinating (frequency)	0	1	2	3	4
Number of times urinating at night	0	1	2	3	4
Bladder does not feel completely empty right after urinating	0	1	2	3	4
Stopping and starting several times while urinating (intermittency)	0	1	2	3	4
Weak urinary stream	0	1	2	3	4
Having to push or strain to begin urination	0	1	2	3	4
				Total Urinary Score _____	
Lack of interest in sexual activity	0	1	2	3	4
Difficulty getting an erection	0	1	2	3	4
Difficulty maintaining an erection	0	1	2	3	4
Difficulty reaching ejaculation	0	1	2	3	4
Pain with ejaculation	0	1	2	3	4
				Total Sexual Score _____	