Prostate Cancer Survivorship Questionnaire

Following prostate cancer treatment, some patients develop erectile dysfunction and/or prolonged bladder health issues. Complete both sides of this questionnaire to assess your sexual and bladder health. Treatment options are available to you, as needed.

Date: _____

Patient name: _____

Birth date: _____

Phone: _____

My urologist: _____

Sexual Health Inventory for Men (SHIM)[1]

Answer the sexual health questions by circling your answers and adding up your score.

Over the past 6 months:

1. How do you rate your confidence that you could get and keep an erection?

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

2. 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	Sometimes	Most times	Almost always or always
0	**1**	**2**	**3**	**4**	**5**

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?

Did not attempt intercourse	Almost never or never	A few times	Sometimes	Most times	Almost always or always
0	**1**	**2**	**3**	**4**	**5**

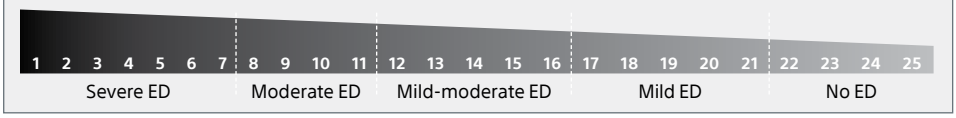
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

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

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt intercourse	Almost never or never	A few times	Sometimes	Most times	Almost always or always
0	**1**	**2**	**3**	**4**	**5**

The Sexual Health Inventory for Men (SHIM) classifies ED severity with the following breakpoints:



SHIM Score
(add the corresponding numbers from questions **1**–**5**)

6. Check ED treatments you have tried:

☐ Pills/Medication ☐ Vacuum Device ☐ Injection Therapy ☐ Suppositories ☐ Wave Therapy ☐ Homeopathic

Please provide any additional information that you would like to discuss (o

_____

_____

_____

1. Cappelleri JC, Rosen RC. The Sexual Health Inventory for Men (SHIM): a 5-year review of research and clinical experience. *Int J Impot Res.* 2005 July-Aug;17(4):307-19.

Please see the reverse side to complete your bladder health assessment

Bladder Health Assessment

1. If you have had prostate cancer, how long ago did you complete your treatment?

_____Years _____Months

2. What prostate cancer treatment did you receive?

- ❑ Radical prostatectomy
- ❑ Radiation therapy
- ❑ Combination therapy (e.g., Radiation and surgery)
- ❑ Medication
- ❑ Other
- ❑ None, I have not had prostate cancer

3. Do you experience urine leakage? If Yes, proceed to the next set of questions. If no, disregard this assessment. ❑ Yes ❑ No

a. How often do you leak urine?
- ❑ About once a week or less (**1**)
- ❑ Two or three times a week (**2**)
- ❑ About once a day (**3**)
- ❑ Several times a day (**4**)
- ❑ All the time (**5**)

b. How much urine do you think usually leaks (whether protection is worn or not)?
- ❑ A small amount (**2**)
- ❑ A moderate amount (**4**)
- ❑ A large amount (**6**)

c. Overall, how much does leaking urine interfere with your everyday life? (circle one)

Not at all **0 1 2 3 4 5 6 7 8 9 10** A great deal

d. When do you leak urine? (select all that apply)
- ❑ Before I can get to the toilet
- ❑ When I cough or sneeze
- ❑ When I am sleeping
- ❑ During sex or upon orgasm
- ❑ When I have finished urinating and am dressed
- ❑ For no obvious reason
- ❑ All the time

e. What solutions have you tried to cope with your bladder leakage? (select all that apply)
- ❑ Lifestyle modifications (decrease liquid consumption, diet changes)
- ❑ Bladder muscle exercise regime (Kegels)
- ❑ Pads or diapers
- ❑ Male sling
- ❑ Artificial urinary sphincter
- ❑ Penile clamp
- ❑ Other

f. How would you feel if you were to spend the rest of your life with your current urinary condition the way it is now? (circle one)

Pleased **0 1 2 3 4 5 6 7 8 9 10** Terrible

Bladder Leakage Score
(add the corresponding numbers from questions **3 a**, **b** and **c**)

Follow the steps to customize this form:

1. Enter the consulting physician's name or names, if multiple
2. Enter office phone number
3. (Office visit)
4. Me
5. — or — Return in provided envelope

Please contact:
Dr. First Last-Name
(###) ### – ####

Please return this questionnaire in the enclosed self-addressed envelope.

If you received this letter in error please disregard.
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