

NIH-Chronic Prostatitis Symptom Index (NIH-CPSI)

PLEASE TICK THE APPROPRIATE ANSWER THAT BEST DESCRIBES HOW YOU FEEL FOR EACH QUESTION.

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

- | | | |
|--|---------------------------------------|---------------------------------------|
| | Yes | No |
| a. Area between rectum and testicles (perineum) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| b. Testicles | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| c. Tip of the penis (not related to urination) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| d. Below your waist, in your pubic or bladder area | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

2. In the last week, have you experienced:

- | | | |
|--|---------------------------------------|---------------------------------------|
| | Yes | No |
| a. Pain or burning during urination? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |
| b. Pain or discomfort during or after sexual climax (ejaculation)? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₀ |

3. How often have you had pain or discomfort in any of these areas over the last week?

- | | | |
|---|---|---|
| <input type="checkbox"/> ₀ Never | <input type="checkbox"/> ₁ Rarely | <input type="checkbox"/> ₂ Sometimes |
| <input type="checkbox"/> ₃ Often | <input type="checkbox"/> ₄ Usually | <input type="checkbox"/> ₅ Always |

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

- | | | | | | | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ | <input type="checkbox"/> ₇ | <input type="checkbox"/> ₈ | <input type="checkbox"/> ₉ | <input type="checkbox"/> ₁₀ |
| NO PAIN | | | | | PAIN AS BAD AS YOU CAN IMAGINE | | | | | |

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- | | |
|---|---|
| <input type="checkbox"/> ₀ Not at all | <input type="checkbox"/> ₁ Less than 1 time in 5 |
| <input type="checkbox"/> ₂ Less than half the time | <input type="checkbox"/> ₃ About half the time |
| <input type="checkbox"/> ₄ More than half the time | <input type="checkbox"/> ₅ Almost always |

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- | | |
|---|---|
| <input type="checkbox"/> ₀ Not at all | <input type="checkbox"/> ₁ Less than 1 time in 5 |
| <input type="checkbox"/> ₂ Less than half the time | <input type="checkbox"/> ₃ About half the time |
| <input type="checkbox"/> ₄ More than half the time | <input type="checkbox"/> ₅ Almost always |

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- | |
|---|
| <input type="checkbox"/> ₀ None |
| <input type="checkbox"/> ₁ Only a little |
| <input type="checkbox"/> ₂ Some |
| <input type="checkbox"/> ₃ A lot |

8. How much did you think about your symptoms, over the last week?

- | |
|---|
| <input type="checkbox"/> ₀ None |
| <input type="checkbox"/> ₁ Only a little |
| <input type="checkbox"/> ₂ Some |
| <input type="checkbox"/> ₃ A lot |

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- | |
|--|
| <input type="checkbox"/> ₀ Delighted |
| <input type="checkbox"/> ₁ Pleased |
| <input type="checkbox"/> ₂ Mostly satisfied |
| <input type="checkbox"/> ₃ Mixed (about equally satisfied and dissatisfied) |
| <input type="checkbox"/> ₄ Mostly dissatisfied |
| <input type="checkbox"/> ₅ Unhappy |
| <input type="checkbox"/> ₆ Terrible |

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain:
Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3, and 4

Urinary Symptoms:
Total of items 5 and 6

Quality of Life Impact:
Total of items 7, 8, and 9