





4. How big a problem, if any, has each of the following been for you during the last 4 weeks?

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Dripping or leaking urine .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| b. Pain or burning on urination .....              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| c. Bleeding with urination.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| d. Weak urine stream or incomplete emptying .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| e. Need to urinate frequently during the day ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |

5. Overall, how big a problem has your urinary function been for you during the last 4 weeks? .....

<input type="checkbox"/>	A-E
No problem .....	A
Very small problem .....	B
Small problem .....	C
Moderate problem.....	D
Big problem.....	E

6. How big a problem, if any, has each of the following been for you?

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Urgency to have a bowel movement .....      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| b. Increased frequency of bowel movements..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| c. Losing control of your stools .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| d. Bloody stools .....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| e. Abdominal/pelvic/rectal pain .....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |

7. Overall, how big a problem have your bowel habits been for you during the last 4 weeks? .....  A-E

No problem .....A  
 Very small problem .....B  
 Small problem .....C  
 Moderate problem .....D  
 Big problem .....E

8. How would you rate each of the following during the last 4 weeks?

a. Your ability to have an erection .....  Very Poor To none  Poor  Fair  Good  Very Good

b. Your ability to reach orgasm (climax) .....  Very Poor To none  Poor  Fair  Good  Very Good

9. How would you describe the usual QUALITY of your erections during the last 4 weeks? .....  A-D

None at all .....A  
 Not firm enough for any sexual activity .....B  
 Firm enough for masturbation and foreplay only .....C  
 Firm enough for intercourse .....D

10. How would you describe the FREQUENCY of your erections during the last 4 weeks? .....  A-E

I NEVER had an erection when I wanted one .....A  
 I had an erection LESS THAN HALF the time I wanted one .....B  
 I had an erection ABOUT HALF the time I wanted one .....C  
 I had an erection MORE THAN HALF the time I wanted one .....D  
 I had an erection WHENEVER I wanted one .....E

11. Overall, how would you rate your ability to function sexually during the last 4 weeks? .....  Very Poor  Poor  Fair  Good  Very Good

12. Overall, how big a problem has your sexual function or lack of sexual function been for you during the last 4 weeks? .....  A-E

No problem .....A

Very small problem .....B

Small problem .....C

Moderate problem .....D

Big problem .....E

13. How big a problem during the last 4 weeks, if any, has each of the following been for you?

- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Hot flashes.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| b. Breast tenderness/enlargement ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| c. Feeling depressed .....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| d. Lack of energy .....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |
| e. Change in body weight .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | No Problem               | Very small Problem       | Small Problem            | Moderate Problem         | Big Problem              |

# PCSI: Prostate Cancer Outcomes Symptom Indexes

REGISTRY ID:

FORM CODE: PCS  
VERSION:A 12/08/11

Event

SEQ #

## ADMINISTRATIVE INFORMATION

0a. Completion Date:   /   /

0b. Staff ID:

**Instructions:** Enter the answer given by the participant for each response.

1. In the past week, how much control did you have over your urine?.....  A-D
  - Had complete control .....A
  - Leaked urine, but only at certain times .....B
  - Leaked urine most of the time .....C
  - Little or no control .....D
  
2. In the past week, how often did you leak urine?.....  A-E
  - Not at all.....A
  - Occasionally (once or twice) .....B
  - Fairly frequently (several times) .....C
  - Frequently (at least once a day).....D
  - Very frequently (several times a day) .....E
  
3. In the past week, if you leaked urine, how much usually comes out?.....  A-D
  - Had complete control (no leaking).....A
  - A few drops.....B
  - Less than a tablespoon .....C
  - More than a tablespoon .....D
  
4. In the past week, how easy has your urine flow been? .....  A-E
  - Very easy .....A
  - Fairly easy .....B
  - Slow, but you don't have to strain or bear down .....C
  - Very slow, and you do have to strain or bear down .....D
  - Very slow, and you have to strain or bear down hard.....E

5. In the past week, how often did you urinate at night?.....  A-D
- Seldom or never.....A
- Once a night .....B
- 2 to 3 times a night.....C
- More than 3 times a night.....D
6. In the past week, how often did you urinate? .....  A-D
- 4 or fewer times a day.....A
- 5 to 8 times a day.....B
- 9 to 12 times a day.....C
- More than 12 times a day.....D
7. In the past week, how often have you felt pain or burning during urination?.....  A-E
- Not at all.....A
- Occasionally (once or twice) .....B
- Fairly frequently (several times) .....C
- Frequently (at least once a day).....D
- Very frequently (several times a day) .....E
8. In the past week, how often did you have the feeling that it is urgent that you pass your urine?.....  A-E
- Not at all.....A
- Occasionally (once or twice) .....B
- Fairly frequently (several times) .....C
- Frequently (at least once a day).....D
- Very frequently (several times a day) .....E
9. In the past week, how often did you have diarrhea or loose, watery stools? .....  A-E
- Not at all.....A
- Occasionally (once or twice) .....B
- Fairly frequently (several times) .....C
- Frequently (at least once a day).....D
- Very frequently (several times a day) .....E
10. In the past week, how often did you have a sense of urgency that you move your bowels? .....  A-E
- Not at all.....A
- Occasionally (once or twice) .....B
- Fairly frequently (several times) .....C
- Frequently (at least once a day).....D
- Very frequently (several times a day) .....E

11. In the past week, how often did you have tenderness or pain when you moved your bowels? .....  A-E

Not at all.....A  
Occasionally (once or twice) .....B  
Fairly frequently (several times) .....C  
Frequently (at least once a day).....D  
Very frequently (several times a day) .....E

12. In the past week, how often did you have bleeding with your bowel movements?.....  A-E

Not at all.....A  
Occasionally (once or twice) .....B  
Fairly frequently (several times) .....C  
Frequently (at least once a day).....D  
Very frequently (several times a day) .....E

13. In the past week, how often did you have abdominal cramping or pain? .....  A-E

Not at all.....A  
Occasionally (once or twice) .....B  
Fairly frequently (several times) .....C  
Frequently (at least once a day).....D  
Very frequently (several times a day) .....E

14. In the past week, how often did you have the feeling that you have an urge to move your bowels, but have nothing to pass? .....  A-E

Not at all.....A  
Occasionally (once or twice) .....B  
Fairly frequently (several times) .....C  
Frequently (at least once a day).....D  
Very frequently (several times a day) .....E

15. In the past 4 weeks, what is the most erect (or hard) your penis has become at any time?.....  A-E

Full erection .....A  
Nearly full erection—sufficient for penetration without manual assistance.....B  
Partial erection—capable of penetration with manual assistance .....C  
Partial erection—not capable of penetration even with manual assistance.....D  
No erection at all .....E



16. In the past 4 weeks, how much difficulty have you had getting an erection during sexual activity? .....  A-E

No difficulty ..... A

A little ..... B

Some ..... C

A lot ..... D

Have not had sexual activity in the past 4 weeks ..... E

17. In the past 4 weeks, how much difficulty have you had keeping an erection during sexual activity? .....  A-E

No difficulty ..... A

A little ..... B

Some ..... C

A lot ..... D

Have not had sexual activity in the past 4 weeks ..... E

18. In the past 4 weeks, have you been able to reach orgasm (sensation of climax)? .....  A-D

Yes, all the time ..... A

Yes, some of the time ..... B

No, not at all ..... C

Have not engaged in sexual activity in the past 4 weeks ..... D

19. In the past 4 weeks, have you been able to ejaculate? .....  A-D

Yes, all the time ..... A

Yes, some of the time ..... B

No, not at all ..... C

Have not engaged in sexual activity in the past 4 weeks ..... D

In the past week, how distressed or worried have you been about each of the following?

- |   |                          |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 20. Leaking urine .....                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 21. Slow or difficult urine flow .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 22. Urinating at night.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 23. Frequent urination.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 24. Pain or burning during urination .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 25. Urgency in urination.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 26. Diarrhea or loose, watery stools.....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 27. Urgency in moving your bowels .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 28. Tenderness or pain when you move<br>your bowels .....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |
| 29. An urge to move your bowels with<br>nothing to pass ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|   | Not at all               | Slightly                 | Moderately               | Quite a bit              | Extremely                |