



ARNOLD PALMER PROSTATE CENTER
AT EISENHOWER LUCY CURCI CANCER CENTER

EPIC The Expanded Prostate Index Composite

This questionnaire is designed to measure Quality of Life issues in men. To help us get the most accurate measurement, it is important that you answer all questions honestly and completely.

Remember, as with all medical records, information contained within this survey will remain strictly confidential.

Urinary Function

This section is about your urinary habits. Please consider **ONLY THE LAST 4 WEEKS**.

1. Over the **past 4 weeks**, how often have you leaked urine?

	More than once a day1
	About once a day2
(circle one number)	More than once a week3
	About once a week4
	Rarely or never5

2. Over the **past 4 weeks**, how often have you urinated blood?

	More than once a day1
	About once a day2
(circle one number)	More than once a week3
	About once a week4
	Rarely or never5

3. Over the **past 4 weeks**, how often have you had pain or burning with urination?

	More than once a day1
	About once a day2
(circle one number)	More than once a week3
	About once a week4
	Rarely or never5

4. Which of the following best describes your urinary control **during the last 4 weeks?**
- No urinary control whatsoever .1
 Frequent dribbling.....2
 Occasional dribbling....3
 Total control.....4
- (circle one number)

5. How many pads or adult diapers per day did you usually use to control leakage **during the last 4 weeks?**
- None1
 1 pad per day.....2
 2 pads per day.....3
 3 or more pads per day.....4
- (circle one number)

6. How big a problem, if any, has each of the following been for you **during the last 4 weeks?** (*Circle one number for each line*)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>
a. Dripping urine or leaking urine....	0	1	2	3	4
b. Pain or burning on urination	0	1	2	3	4
c. Bleeding with urination	0	1	2	3	4
d. Weak urine stream or incomplete emptying	0	1	2	3	4
e. Waking up to urinate	0	1	2	3	4
f. Need to urinate frequently during the day	0	1	2	3	4

7. Overall, how big a problem has your urinary function been for you **during the last 4 weeks?**
- No problem1
 Very small problem.....2
 Small problem3
 Moderate problem4
 Big problem.....5
- (circle one number)

Bowel Habits

The next section is about your bowel habits and abdominal pain.
Please consider **ONLY THE LAST 4 WEEKS.**

8. How often have you had rectal urgency (felt like I had to pass stool, but did not) **during the last 4 weeks?**

- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5

9. How often have you had uncontrolled leakage of stool or feces?

- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5

10. How often have you had stools (bowel movements) that were loose or liquid (no form, watery, mushy) **during the last 4 weeks?**

- (circle one number)
- Never.....1
 - Rarely.....2
 - About half the time.....3
 - Usually.....4
 - Always.....5

11. How often have you had bloody stools **during the last 4 weeks?**

- (circle one number)
- Never.....1
 - Rarely.....2
 - About half the time.....3
 - Usually.....4
 - Always.....5

12. How often have your bowel movements been painful **during the last 4 weeks?**

- (circle one number)
- Never.....1
 - Rarely.....2
 - About half the time.....3
 - Usually.....4
 - Always.....5

13. How many bowel movements have you had on a typical day **during the last 4 weeks?**

- (circle one number)
- Two or less.....1
 - Three to four.....2
 - Five or more.....3

14. How often have you had crampy pain in your abdomen, pelvis or rectum **during the last 4 weeks?**

- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5

15. How big a problem, if any, has each of the following been for you **during the last 4 weeks?** (*Circle one number for each line*)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>
a. Urgency to have a bowel movement.....	0	1	2	3	4
b. Increased frequency of bowel movements.....	0	1	2	3	4
c. Watery bowel movements.....	0	1	2	3	4
d. Losing control of your stools.....	0	1	2	3	4
e. Bloody stools.....	0	1	2	3	4
f. Abdominal/Pelvic/Rectal pain ...	0	1	2	3	4

16. Overall, how big a problem have your bowel habits been for you **during the last 4 weeks?**

- (circle one number)
- No problem1
 - Very small problem.....2
 - Small problem3
 - Moderate problem4
 - Big problem.....5

Sexual Function

The next section is about your **current** sexual function and sexual satisfaction. Many of the questions are very personal, but they will help us understand the important issues that you face every day. Remember, **THIS SURVEY INFORMATION IS COMPLETELY CONFIDENTIAL**. Please answer honestly about **THE LAST 4 WEEKS ONLY**.

17. How would you rate each of the following **during the last 4 weeks?**
(Circle one number for each line)

	<u>Very Poor to None</u>	<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>Very Good</u>
a. Your level of sexual desire?.....	0	1	2	3	4
b. Your ability to have an erection.....	0	1	2	3	4
c. Your ability to reach orgasm (climax)?	0	1	2	3	4

18. How would you describe the usual **QUALITY** of your erections **during the last 4 weeks?**

	None at all.....	1
	Not firm enough for any sexual activity	2
(circle one number)	Firm enough for masturbation and foreplay only...	3
	Firm enough for intercourse.....	4

19. How would you describe the **FREQUENCY** of your erections **during the last 4 weeks?**

	I NEVER had an erection when I wanted one.....	1
	I had an erection LESS THAN HALF the time I wanted one ...	2
(circle one number)	I had an erection ABOUT HALF the time I wanted one.....	3
	I had an erection MORE THAN HALF the time I wanted one...	4
	I had an erection WHENEVER I wanted one.....	5

20. How often have you awakened in the morning or night with an erection **during the last 4 weeks?**

	Never.....	1
	Less than once a week.....	2
(circle one number)	About once a week.....	3
	Several times a week.....	4
	Daily.....	5

21. **During the last 4 weeks**, how often did you have any sexual activity?
 (circle one number)

Not at all.....1
 Less than once a week.....2
 About once a week.....3
 Several times a week.....4
 Daily.....5

22. **During the last 4 weeks**, how often did you have sexual intercourse?
 (circle one number)

Not at all.....1
 Less than once a week.....2
 About once a week.....3
 Several times a week.....4
 Daily.....5

23. Overall, how would you rate your ability to function sexually **during the last 4 weeks**?
 (circle one number)

Very poor.....1
 Poor.....2
 Fair.....3
 Good.....4
 Very good.....5

24. How big a problem, if any, has each of the following been for you **during the last 4 weeks**? (*Circle one number for each line*)

	No <u>Problem</u>	Very Small <u>Problem</u>	Small <u>Problem</u>	Moderate <u>Problem</u>	Big <u>Problem</u>
a. Your level of sexual desire.....	0	1	2	3	4
b. Your ability to have an erection...	0	1	2	3	4
c. Your ability to reach an orgasm...	0	1	2	3	4

25. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks**?
 (circle one number)

No problem1
 Very small problem.....2
 Small problem3
 Moderate problem4
 Big problem.....5

Hormonal Function

The next section is about your hormonal function. Please consider **ONLY THE LAST 4 WEEKS.**

26. Over **the last 4 weeks**, how often have you experienced hot flashes?
- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5
27. How often have you had breast tenderness during **the last 4 weeks**?
- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5
28. **During the last 4 weeks**, how often have you felt depressed?
- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5
29. **During the last 4 weeks**, how often have you felt a lack of energy?
- (circle one number)
- More than once a day1
 - About once a day2
 - More than once a week3
 - About once a week4
 - Rarely or never5
30. How much change in your weight have you experienced **during the last 4 weeks**, if any?
- (circle one number)
- Gained 10 pounds or more1
 - Gained less than 10 pounds.....2
 - No change in weight.....3
 - Lost less than 10 pounds.....4
 - Lost 10 pounds or more.....5

31. How big a problem, if any, has each of the following been for you **during the last 4 weeks?** (*Circle one number for each line*)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>
a. Hot flashes.....	0	1	2	3	4
b. Breast tenderness/enlargement...	0	1	2	3	4
c. Loss of body hair.....	0	1	2	3	4
d. Feeling depressed.....	0	1	2	3	4
e. Lack of energy.....	0	1	2	3	4
f. Change in body weight.....	0	1	2	3	4

Overall Satisfaction

32. Overall, how satisfied are you with the treatment you received at the Arnold Palmer Prostate Center?

- (circle one number)
- Extremely dissatisfied1
 - Dissatisfied.....2
 - Uncertain.....3
 - Satisfied.....4
 - Extremely Satisfied.....5