ACSS Questionnaire

First visit (diagnostic form) - Part A

Time: _____:_____ Date of evaluation: / / (dd/mm/yyyy)

Please indicate whether you have had the following symptoms during the past 24 hours, and how severe they were:
(Please mark ✓only one answer for each symptom)

			0	1	2	3
Typical	1	Frequent urination of small volumes of urine *(going to the toilet very often)*	☐ No *4 or less times per day*	☐ Yes, mild *5-6 times/ day*	☐ Yes, moderate *7-8 times/day*	☐ Yes, severe *9-10 or more times/day*
	2	Urgent urination *(a strong and uncontrollable urge to pass urine)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	3	Feeling pain or burning when passing urine	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	4	Incomplete bladder emptying after urination	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	5	Pain or uncomfortable pressure in the lower abdomen *(suprapubic area)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	6	Visible blood in your urine	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
					Sum of "Typical" scores=	**points**
Differential	7	Loin *(low back)* pain *(may be limited to only one body side)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	8	Vaginal discharge *(especially in the mornings)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	9	Urethral discharge *(without urination)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	10	High body temperature *(chills/fever)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
		(Please indicate ✓if measured)	≤37.5 ˚C	37.6-37.9 ˚C	38.0-38.9 ˚C	≥39.0 ˚C
					Sum of "Differential" scores=	**points**

Quality of life	11	**Please give an overall rating of how much these symptoms, mentioned above, bothered you in the past 24 hours *(Please mark ✓only one answer)***
		☐ 0 Do not feel any discomfort *(No symptoms at all. Felt as good as usual)*
		☐ 1 Feeling little discomfort *(Feeling somewhat worse than usual)*
		☐ 2 Feeling moderate discomfort *(Feeling quite bad)*
		☐ 3 Feeling extreme discomfort *(Feeling terrible)*
	12	**Please choose the number, which most closely describes your normal work/everyday activities were affected by your symptoms, mentioned above, in the past 24 hours *(Please mark ✓only one answer)***
		☐ 0 Not affected at all *(Carrying out usual daily activities)*
		☐ 1 Mildly affected *(Able to carry out daily activities with some discomfort)*
		☐ 2 Moderately affected *(Only able to carry out daily activities with significant effort)*
		☐ 3 Extremely affected *(Almost impossible to carry out daily activities)*
	13	**Please indicate, how much your social activities were affected by your symptoms, mentioned above, in the past 24 hours *(Please mark ✓only one answer)***
		☐ 0 Not affected at all *(Able to enjoy normal social activities)*
		☐ 1 Mildly affected *(Not able to do some social activities)*
		☐ 2 Moderately affected *(Only able to do a few social activities)*
		☐ 3 Extremely affected *(Not able to do any social activity - symptoms keep me a 'prisoner' in my home)*
		Sum of "QoL" scores= points

Additional	14	**Please indicate whether you have the followings today:**		
		Menstruation *(women's monthly period)* ?	☐ No	☐ Yes
		Premenstrual symptoms?	☐ No	☐ Yes
		Symptoms of the menopause ?	☐ No	☐ Yes
		Are you pregnant?	☐ No	☐ Yes
		Do you have diabetes mellitus *(sugar diabetes)* ?	☐ No	☐ Yes

Please do not forget to return completed questionnaire back to your physician

STOP **Thank you for cooperation**

ACSS Questionnaire

Control visit (follow-up form) - Part B

Time: _____:_____ Date of evaluation: / / (dd/mm/yyyy)

Please indicate if you experienced any changes in your symptoms since you last completed the first part of this questionnaire
(Please mark ✓ only one answer for each symptom)

Dynamics

- ☐ 0 Now I feel back to normal *(All symptoms have gone away)*
- ☐ 1 Now I feel much better *(Majority of symptoms has gone away)*
- ☐ 2 Now I feel only somewhat better *(Majority of symptoms is still present)*
- ☐ 3 No changes, now I feel about the same *(No changes in my symptoms)*
- ☐ 4 Now I feel worse *(My condition is worse)*

Please indicate whether you have had the following symptoms during the past 24 hours, and how severe they were:
(Please mark ✓ only one answer for each symptom)

			0	1	2	3
Typical	1	Frequent urination of small volumes of urine *(going to the toilet very often)*	☐ No *4 or less times per day*	☐ Yes, mild *5-6 times/ day*	☐ Yes, moderate *7-8 times/day*	☐ Yes, severe *9-10 or more times/day*
	2	Urgent urination *(a strong and uncontrollable urge to pass urine)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	3	Feeling pain or burning when passing urine	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	4	Incomplete bladder emptying after urination	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	5	Pain or uncomfortable pressure in the lower abdomen *(suprapubic area)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	6	Visible blood in your urine	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
					Sum of "Typical" scores=	**points**
Differential	7	Loin *(low back)* pain *(may be limited to only one body side)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	8	Vaginal discharge *(especially in the mornings)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	9	Urethral discharge *(without urination)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	10	High body temperature *(chills/fever)*	☐ No	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
		(Please indicate ✓ if measured)	≤37.5 C	37.6-37.9 C	38.0-38.9 C	≥39.0
					Sum of "Differential" scores=	**points**

Quality of life

11 **Please give an overall rating of how much these symptoms, mentioned above, bothered you in the past 24 hours** ***(Please mark ✓ only one answer)***

- ☐ 0 Do not feel any discomfort *(No symptoms at all. Felt as good as usual)*
- ☐ 1 Feeling little discomfort *(Feeling somewhat worse than usual)*
- ☐ 2 Feeling moderate discomfort *(Feeling quite bad)*
- ☐ 3 Feeling extreme discomfort *(Feeling terrible)*

12 **Please choose the number, which most closely describes your normal work/everyday activities were affected by your symptoms, mentioned above, in the past 24 hours** ***(Please mark ✓ only one answer)***

- ☐ 0 Not affected at all *(Carrying out usual daily activities)*
- ☐ 1 Mildly affected *(Able to carry out daily activities with some discomfort)*
- ☐ 2 Moderately affected *(Only able to carry out daily activities with significant effort)*
- ☐ 3 Extremely affected *(Almost impossible to carry out daily activities)*

13 **Please indicate, how much your social activities were affected by your symptoms, mentioned above, in the past 24 hours** ***(Please mark ✓ only one answer)***

- ☐ 0 Not affected at all *(Able to enjoy normal social activities)*
- ☐ 1 Mildly affected *(Not able to do some social activities)*
- ☐ 2 Moderately affected *(Only able to do a few social activities)*
- ☐ 3 Extremely affected *(Not able to do any social activity - symptoms keep me a 'prisoner' in my home)*

Sum of "QoL" scores= points

Additional

14 **Please indicate whether you have the followings today:**

Menstruation *(women's monthly period)* ?	☐ No	☐ Yes
Premenstrual symptoms?	☐ No	☐ Yes
Symptoms of the menopause ?	☐ No	☐ Yes
Are you pregnant?	☐ No	☐ Yes
Do you have diabetes mellitus *(sugar diabetes)*?	☐ No	☐ Yes

STOP

Please do not forget to return completed questionnaire back to your physician

Thank you for cooperation