



METROUROLOGY
Cancer Center

For Office Use ONLY

Date data entered ___ / ___ / ___

Initials _____

Time period: (Circle one)

baseline 3 mo. 6 mo. 9 mo.

12 mo. 18 mo. 24 mo.

EPIC Questionnaire

The Expanded Prostate Cancer Index Composite

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

This questionnaire will help us to provide you with the best care possible in regards to prostate cancer. It will also help us to evaluate our patients before, during and after treatment.

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

CONFIDENTIAL

Today's date (please enter the date of when you are filling out this form): Month ____ Day ____ Year ____

How long has it been since your procedure/surgery? (*Please check one*)

Before surgery 3 mos 6 mos 9 mos 12 mos 18 mos 2 years 3 years 4 years 5 years

Patient's Label here

URINARY FUNCTION – This section is about your urinary habits. Please consider **ONLY THE LAST 4 WEEKS.** (circle one number)

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

More than once a day.....1 More than once a week 3 Rarely or never 5
 About once per day 2 About once a week 4

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

More than once a day.....1 More than once a week 3 Rarely or never 5
 About once per day 2 About once a week 4

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

More than once a day 1 More than once a week 3 Rarely or never 5
 About once per day 2 About once a week 4

4. Which of the following best describes your urinary control **during the past 4 weeks**?

No urinary control whatsoever 1 Occasional dribbling 3
 Frequent dribbling 2 Total control 4

5. How many pads or adult diapers per day did you usually use to control leakage, **during the past 4 weeks**?

None 1 2 pads per day 3
 1 pad per day 2 3 or more pads per day 4

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

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|--|-----------------------|-------------------------------|--------------------------|-----------------------------|------------------------|
| a. Dripping 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 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**?
 (circle one number)

No problem1 Small problem3 Big problem5
 Very small problem2 Moderate problem4

URINARY SYMPTOMS –

(circle one number on each line)

| | <u>Not at all</u> | <u>Less than 1 time in 5</u> | <u>Less than half the time</u> | <u>About half the time</u> | <u>More than half the time</u> | <u>Almost always</u> |
|--|----------------------------------|---|---|---|---|---------------------------------|
| 8. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished? | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. Frequency Over the past month, how often have you had to urinate again, less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| 11. Urgency Over the past month, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 12. Weak stream Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| 13. Straining Over the past month, how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 14. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | (none) 0 | (1x) 1 | (2x) 2 | (3x) 3 | (4x) 4 | (5 or more) 5 |

BOWEL HABITS – the next section is about your bowel habits and abdominal pain. Please consider **ONLY THE LAST 4 WEEKS.** (circle one number)

15. How often have you had rectal urgency (felt like you had to pass stool, but did nothing) **during the past 4 weeks?**

More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

16. How often have you had uncontrolled leakage of stool or feces **during the past 4 weeks?**

More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

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

Never 1 About half the time 3 Always 5
 Rarely 2 Usually 4

18. How often have you had bloody stools **during the past 4 weeks?**

Never 1 About half the time 3 Always 5
 Rarely 2 Usually 4

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

Never 1 About half the time 3 Always 5
 Rarely 2 Usually 4

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

Two or less 1 Three to four 2 Five or more 3

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

More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

22. How big a problem, if any, has each of the following been for you? (circle one number on each line)

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|---|-----------------------|-------------------------------|--------------------------|-----------------------------|------------------------|
| 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 |

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

No problem 1 Small problem 3 Big problem 5
 Very small problem 2 Moderate problem 4

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 important issues that you face every day. Remember, THIS SURVEY INFORMATION IS COMPLETELY **CONFIDENTIAL**. Please answer honestly about the **LAST 4 WEEKS ONLY**. (circle one number)

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

| | Very poor to none | Poor | Fair | Good | Very good |
|---|----------------------------------|-------------|-------------|-------------|----------------------|
| a. Your level of sexual desire? | 1 | 2 | 3 | 4 | 5 |
| b. Your ability to have an erection? | 1 | 2 | 3 | 4 | 5 |
| c. Your ability to reach orgasm (climax)? | 1 | 2 | 3 | 4 | 5 |

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

| | | | |
|---|---|--|---|
| None at all | 1 | Firm enough for masturbation and foreplay only | 3 |
| Firm enough for any sexual activity | 2 | Firm enough for intercourse | 4 |

26. How would you describe the **FREQUENCY** of your erections **during the past 4 weeks?**

| Never | Less than half the time | About half the time | More than half the time | Whenever I wanted |
|--------------|------------------------------------|----------------------------|------------------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |

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

| | | | | | |
|-----------------------------|---|----------------------------|---|-------------|---|
| Never | 1 | About once a week | 3 | Daily | 5 |
| Less than once a week | 2 | Several times a week | 4 | | |

28. **During the last 4 weeks**, how often did you have any sexual activity?

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

29. **During the last 4 weeks**, how often did you have sexual intercourse?

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

30. Overall, how would you rate your ability to function sexually **during the past 4 weeks?**

| | | | | | |
|-----------------|---|------------|---|-----------------|---|
| Very poor | 1 | Fair | 3 | Very good | 5 |
| Poor | 2 | Good | 4 | | |

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

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|-------------------------------------|-----------------------|-------------------------------|--------------------------|-----------------------------|------------------------|
| 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 |

32. Over all, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks?**

| | | | | | |
|--------------------------|---|------------------------|---|-------------------|---|
| No problem | 1 | Small problem | 3 | Big problem | 5 |
| Very small problem | 2 | Moderate problem | 4 | | |

HORMONAL FUNCTION – The next section is about your hormonal function. Please consider **ONLY THE LAST 4 WEEKS.** (circle one number)

33. Over the last 4 weeks, how often have you experienced hot flashes?
 More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

34. How often have you had breast tenderness **during the last 4 weeks?**
 More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

35. **During the last 4 weeks,** how often have you felt depressed?
 More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

36. **During the last 4 weeks,** how often have you felt a lack of energy?
 More than once a day 1 More than once a week 3 Rarely or never 5
 About once a day 2 About once a week 4

37. How much change in your weight have you experienced **during the last 4 weeks?**
 Gained 10 pounds or more 1 No change in weight 3 Lost 10 pounds or more ... 5
 Gained less than 10 pounds 2 Lost less than 10 pounds 4

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

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|----------------------------------|-------------------|---------------------------|----------------------|-------------------------|--------------------|
| 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

39. Overall, how satisfied are you with the treatment you received for your prostate cancer?
 Extremely dissatisfied 1 Uncertain 3 Extremely satisfied 5
 Dissatisfied 2 Satisfied 4

FINAL SECTION – These last questions are about your household and your general medical history. These items are very important for our research. Please answer honestly. (circle one number)

The following questions are important and will help us to determine whether or not there are other issues that may affect our patients during their medical care. We ask that you complete the questions that you are comfortable answering. Again remember, as with all medical records, information contained within this survey will remain strictly confidential.

If you have had a hospital based treatment/surgery to treat your prostate cancer, please answer the following questions.

1. After your treatment/surgery, when were you able to return to work?
 _____ (days weeks months)
 (enter number) (circle one)

2. After your treatment/surgery, when were you able to complete your normal daily activities?
 _____ (days weeks months)
 (enter number) (circle one)

If you have completed the section below within the past year, you do not have to complete it today.

1. How do you describe yourself (optional)?

White/ Caucasian (not Latino/Hispanic) 1 Asian/Oriental/Pacific Islander 4
 Black/ African American (not Latino/Hispanic) ... 2 American Indian/ Native Alaskan 5
 Latino/Hispanic/ Mexican American 3 Other, please specify _____ 6

2. Which of the following best describes your current relationship?

Living with spouse 1 In a significant relationship, but not living together 2
 Not in a relationship3

3. What is your current marital status?

Never married 1 Married 2 Separated3 Divorced 4 Widowed5

4. Are you now working at a paying job?

Yes, full time 1 Yes, part time....2 No, but looking for a job3 No, retired 4

5. Do you currently smoke cigarettes?

No 1 Yes 2

5a. Do you currently use chewing tobacco?

No.....1 Yes.....2

6. Have you **EVER had any of the following treatments for prostate cancer? (please circle YES or NO for every item and fill in the month and year during which therapy was started)**

| | <u>NO</u> | <u>Yes</u> | |
|--|------------------|-------------------|---------------------------------------|
| a. Radical prostatectomy (surgery to remove the prostate through the abdomen or perineum, or by using a laparoscope) | 1 | 2 | Month & Year of surgery ____ / ____ |
| b. External Beam Radiation | 1 | 2 | Month & Year completed ____ / ____ |
| c. Radioactive Seed Implantation (brachy therapy) | 1 | 2 | Month & Year of surgery ____ / ____ |
| d. Expectant management (watchful waiting) | 1 | 2 | Month & Year of diagnosis ____ / ____ |
| e. Orchiectomy (surgical removal of testes) | 1 | 2 | Month & Year of surgery ____ / ____ |

- f. Hormone Deprivation therapy shots 1 2 Month & Year started ____ / ____
- g. Hormone pills (Flutamide, Nilandron or Casodex) 1 2 Month & Year started ____ / ____
- h. Other _____

7. Which therapy, if any, do you **currently** use to improve your erections?

- None at all 0 MUSE (intra-urethral alprostadil) 4
- Vacuum erection device1 Viagra5
- Penile injection therapy2 Other _____6
- Penile prosthesis3

8. Have you **EVER** had any of the following medical conditions? (circle **YES** or **NO** for every item)

- | | <u>NO</u> | <u>Yes</u> |
|--|------------------|-------------------|
| a. Diabetes | 1 | 2 |
| b. Heart attack, chest pain | 1 | 2 |
| c. Stroke | 1 | 2 |
| d. Amputation | 1 | 2 |
| e. Circulation problems in your legs or feet | 1 | 2 |
| f. Asthma, emphysema, or breathing problems | 1 | 2 |
| g. Stomach ulcer | 1 | 2 |
| h. Kidney disease | 1 | 2 |
| i. Major depression | 1 | 2 |
| j. Seizures | 1 | 2 |
| k. Alcoholism or alcohol problem | 1 | 2 |
| l. Drug problems | 1 | 2 |
| m. Exposure to Agent Orange | 1 | 2 |

9. How much schooling did you complete?

- | | |
|---|--|
| Grade school or less 1 | Some college 4 |
| Some high school or technical school 2 | College graduate 5 |
| High school or technical school graduate 3 | Graduate or professional school after college6 |

10. What is your approximate annual combined household income?

- Less than \$10,000 1
- \$10,001 - \$30,0002
- \$30,001 – \$100,000 3
- More than \$100,000..... 4

Thank you for completing this questionnaire!