	Participant ID: _____	Pin # _____
	Discovery Site: _____	Clinical Center _____
	CRF Date: ____/____/____	Visit #: _____

MALE GENITOURINARY PAIN INDEX

Male Participant completes this form via online survey at **ALL Clinic and Online contacts.**

Pain or Discomfort

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

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

2. In the last week, have you experienced:

a. Pain or burning during urination?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
b. Pain or discomfort during or after sexual climax (ejaculation)?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
c. Pain or discomfort as your bladder fills?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
d. Pain or discomfort relieved by voiding?	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
No Pain					Pain as bad as you can imagine					

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	

	Participant ID: _____	Pin # _____
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MALE GENITOURINARY PAIN INDEX

Male Participant completes this form via online survey at **ALL Clinic and Online contacts.**

- | | |
|--|--|
| <p>7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?</p> | <p><input type="checkbox"/>₀ None
 <input type="checkbox"/>₁ Only a little
 <input type="checkbox"/>₂ Some
 <input type="checkbox"/>₃ A lot</p> |
| <p>8. How much did you think about your symptoms, over the last week?</p> | <p><input type="checkbox"/>₀ None
 <input type="checkbox"/>₁ Only a little
 <input type="checkbox"/>₂ Some
 <input type="checkbox"/>₃ A lot</p> |
| <p>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?</p> | <p><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</p> |

Scoring

- | | |
|--|----------------------|
| 10. Pain subscale: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 2c, 2d, 3, and 4 | = _____ (range 0-23) |
| 11. Urinary subscale: Total of items 5 and 6 | = _____ (range 0-10) |
| 12. QOL Impact: Total of items 7, 8, and 9 | = _____ (range 0-12) |
| 13. Total score: Sum of subscale scores | = _____ (range 0-45) |