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American English ACSS© Questionaire

Part A - FIRST VISIT (diagnostic part)

Time:___:__ Date of evaluation: ___/____/_____ (mm/dd/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 Symptoms	1	Frequent urination of small amounts of urine *(going to the toilet very often)*	☐ None, normal,up to *approx.. 4 times per day*	☐ Yes, slightly more often than normal, approx *5-6 times/day*	☐ Yes, noticeably more often than usual, approx. 7-*8 times/day*	☐ Yes, very frequent *approx.. 9-10 or more times/day*
	2	Urgent urination *(a sudden and uncontrollable urge to urinate)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	3	Feeling burning pain when urinating	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	4	Feeling incomplete bladder emptying (*Still feel like you need to urinate after urination*)	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	5	Feeling pain not associated with urination in the lower abdomen *(below the belly button)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	6	Blood seen in urine *(without menses)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
					Sum of "Typical" scores=	**points**
Differential	7	Flank pain *(pain in one or both sides of the lower back)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	8	Abnormal vaginal discharge *(abnormal amount, color and/or odor)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	9	Discharge from the urethra (*urinary opening*) without urination	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	10	Feeling high body temperature/fever Temperature measured ☐ No ☐ Yes	☐ None (≤99.5˚F)	☐ Yes, mild (99.6˚F-100.2˚F)	☐ Yes, moderate (100.3°F-102.0°F)	☐ Yes, severe (≥102.1 ˚F)
					Sum of "Differential" scores=	**points**
Quality of Life	11	**Please rate how much the above-mentioned symptoms have affected your quality of life in the past 24 hours *(Please mark only one answer)*:** ☐ 0 No discomfort *(No symptoms at all. I feel as good as usual)* ☐ 1 Mild discomfort *(I feel a little worse than usual)* ☐ 2 Moderate discomfort *(I feel much worse than usual)* ☐ 3 Severe discomfort *(I feel terrible)*				
	12	**Please indicate how these symptoms have interfered with your everyday activities/work in the past 24 hours *(Please mark only one answer)*:** ☐ 0 Did not interfere at all *(Working as usual on a working day)* ☐ 1 Mildly interfered *(Due to the symptoms, I work slightly less)* ☐ 2 Moderately interfered *(Daily work requires effort)* ☐ 3 Severely interfered *(I almost cannot work)*				
	13	**Please indicate how these symptoms have interfered with your social activities *(visiting people, meeting with friends, etc)* in the past 24 hours *(Please mark only one answer)*:** ☐ 0 Did not interfere at all *(My social activities did not change in any way, I live as usual)* ☐ 1 Mildly interfered (*Insignificant decrease in activities)* ☐ 2 Moderately interfered *(Significant decrease. I have to spend more time at home)* ☐ 3 Severely interfered *(It's terrible. I barely left the house)*				
					Sum of "QoL" scores=	**points**
Additional	14	**Please indicate whether you have the following at the time of completion of this questionnaire:**				
		Menstruation (Menses)?			☐ No	☐ Yes
		Premenstrual syndrome *(PMS)*?			☐ No	☐ Yes
		Signs of menopausal syndrome *(e.g. hot flashes)* ***?***			☐ No	☐ Yes
		Pregnancy ?			☐ No	☐ Yes
		Known (diagnosed) diabetes mellitus *(high sugar) ?*			☐ No	☐ Yes

Alidjanov et al 2020 Antibiotics (Basel) 9(12): 929; https://pubmed.ncbi.nlm.nih.gov/33352734/

American English ACSS© Questionaire

Part B - FOLLOW-UP VISIT (patient-reported outcome)

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

Please indicate if you experienced any changes in your symptoms since the first time you completed this questionaire

Dynamics

- ☐ 0 Yes, I feel back to normal *(All symptoms are completely gone)*
- ☐ 1 Yes, I feel much better *(Most of the symptoms are gone)*
- ☐ 2 Yes, I feel somewhat better *(Only some symptoms are gone)*
- ☐ 3 No, there are barely any changes *(I still have about the same symptoms)*
- ☐ 4 Yes, 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 Symptoms	**1**	Frequent urination of small amounts of urine *(going to the toilet very often)*	☐ None *up to 4 times per day*	☐ Yes, mild *5-6 times/day*	☐ Yes, moderate *7-8 times/day*	☐ Yes, severe *9-10 or more*
	2	Urgent urination *(a sudden and uncontrollable urge to urinate)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	3	Feeling burning pain when urinating	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	4	Feeling incomplete bladder emptying (*Still feel like you need to urinate again after urination*)	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	5	Feeling pain not associated with urination in the lower abdomen (*below the belly button*)	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	6	Blood seen in urine *(without menses)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
					Sum of "Typical" scores=	**points**
Differential	**7**	Flank pain *(pain in one or both sides of the lower back)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	8	Abnormal vaginal discharge *(abnormal amount, color and/or odor)*	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	9	Discharge from the urethra (*urinary opening)* without urination	☐ None	☐ Yes, mild	☐ Yes, moderate	☐ Yes, severe
	10	Feeling high body temperature/fever Temperature measured ☐ No ☐ Yes	☐ None (≤99.5˚F)	☐ Yes, mild (99.6˚F-100.2˚F)	☐ Yes, moderate (100.3˚F-102.0˚F)	☐ Yes, severe (≥102.1 ˚F)
					Sum of "Differential" scores=	**points**

Quality of Life

11 **Please rate how much the above-mentioned symptoms have affected your quality of life in the past 24 hours *(Please mark only one answer)*:**

- ☐ 0 No discomfort *(No symptoms at all. I feel as good as usual)*
- ☐ 1 Mild discomfort *(I feel a little worse than usual)*
- ☐ 2 Moderate discomfort *(I feel much worse than usual)*
- ☐ 3 Severe discomfort *(I feel terrible)*

12 **Please indicate how these symptoms have interfered with your everyday activities/work in the past 24 hours *(Please mark only one answer)*:**

- ☐ 0 Did not interfere at all *(Working as usual on a working day)*
- ☐ 1 Mildly interfered *(Due to the symptoms, I work slightly less)*
- ☐ 2 Moderately interfered *(Daily work requires effort)*
- ☐ 3 Severely interfered *(I almost cannot work)*

13 **Please indicate how these symptoms have interfered with your social activities *(visiting people, meeting with friends, etc)* in the past 24 hours *(Please mark only one answer)*:**

- ☐ 0 Did not interfere at all *(My social activities did not change in any way, I live as usual)*
- ☐ 1 Mildly interfered *(Insignificant decrease in activities)*
- ☐ 2 Moderately interfered *(Significant decrease. I have to spend more time at home)*
- ☐ 3 Severely interfered *(It's terrible. I barely left the house)*

Sum of "QoL" scores= points

Additional

14 **Please indicate whether you have the following at the time of completion of this questionnaire:**		
Menstruation *(Menses)* ?	☐ No	☐ Yes
Premenstrual syndrome *(PMS)* ?	☐ No	☐ Yes
Signs of menopausal syndrome *(e.g. hot flashes)* **?**	☐ No	☐ Yes
Pregnancy ?	☐ No	☐ Yes
Known *(diagnosed)* diabetes mellitus *(high sugar) ?*	☐ No	☐ Yes

Alidjanov et al 2020 Antibiotics (Basel) 9(12): 929; https://pubmed.ncbi.nlm.nih.gov/33352734/