

Attachment 1: American English Acute Cystitis Symptom Score (ACSS) – Questionnaire

Adapted from: Alidjanov JF, Naber KG, Pilatz A, Wagenlehner FM. Validation of the American English Acute Cystitis Symptom Score. Antibiotics (Basel). 2020 Dec 19;9(12):929. DOI: 10.3390/antibiotics9120929

NB: Question 11 slightly modified

FIRST VISIT – Part A (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)	<input type="checkbox"/> None up to 4 times per day	<input type="checkbox"/> Yes, mild 5–6 times/day	<input type="checkbox"/> Yes, moderate 7–8 times/day	<input type="checkbox"/> Yes, severe 9–10 or more times/day
	2	Urgent urination (a sudden and uncontrollable urge to urinate)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	3	Feeling burning pain when urinating	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	4	Feeling incomplete bladder emptying (Still feel like you need to urinate after urination)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	5	Feeling pain not associated with urination in the lower abdomen (below the belly button)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	6	Blood seen in urine (without menses)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
Sum of “Typical” scores=					points	
Differential	7	Flank pain (pain in one or both sides of the lower back)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	8	Abnormal vaginal discharge (abnormal amount, color and/or odor)	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	9	Discharge from the urethra (urinary opening) without urination	<input type="checkbox"/> None	<input type="checkbox"/> Yes, mild	<input type="checkbox"/> Yes, moderate	<input type="checkbox"/> Yes, severe
	10	a) Feeling high body temperature/fever b) Temperature measured <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> None (≤99.5°F)	<input type="checkbox"/> Yes, mild (99.6°F–100.2°F)	<input type="checkbox"/> Yes, moderate (100.3°F–102.0°F)	<input type="checkbox"/> Yes, severe (≥102.1°F)
Sum of “Differential” scores=					points	
Quality of Life	11	Please indicate how these symptoms have interfered with your quality of life in the past 24 hours (Please mark only one answer):				
		<input type="checkbox"/> 0 Did not interfere at all (I feel as good as usual) <input type="checkbox"/> 1 Mildly interfered (I feel a little worse than usual) <input type="checkbox"/> 2 Moderately interfered (I feel much worse than usual) <input type="checkbox"/> 3 Severely interfered (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):				
	<input type="checkbox"/> 0 Did not interfere at all (Working as usual on a working day) <input type="checkbox"/> 1 Mildly interfered (Due to the symptoms, I work slightly less) <input type="checkbox"/> 2 Moderately interfered (Daily work requires effort) <input type="checkbox"/> 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):				
	<input type="checkbox"/> 0 Did not interfere at all (My social activities did not change in any way, I live as usual) <input type="checkbox"/> 1 Mildly interfered (Insignificant decrease in activities) <input type="checkbox"/> 2 Moderately interfered (Significant decrease. I have to spend more time at home) <input type="checkbox"/> 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)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
		Premenstrual syndrome (PMS)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
		Signs of menopausal syndrome (e.g. hot flashes)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
		Pregnancy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
	Known (diagnosed) diabetes mellitus (high sugar)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
FOLLOW-UP Visit – Part B (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 questionnaire						
Dynamics	<input type="checkbox"/> 0 Yes, I feel back to normal (All symptoms are completely gone) <input type="checkbox"/> 1 Yes, I feel much better (Most of the symptoms are gone) <input type="checkbox"/> 2 Yes, I feel somewhat better (Only some symptoms are gone) <input type="checkbox"/> 3 No, there are barely any changes (I still have about the same symptoms) <input type="checkbox"/> 4 Yes, I feel worse (My condition is worse)					
	All questions of Part A, 1–14, follow here in Part B as well					