

STONE: CLINICAL SCREENING FORM

<div style="border: 1px solid black; padding: 2px; display: inline-block;">G</div> Site	Participant ID (Obtain from drug label) <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div>
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1. Visit date (mm/dd/yyyy)	SDATE	<div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
2. Name of person completing this form _____		Initials SINITs <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div>

A. Demographics and Social Characteristics

3. Age	SAGE	<div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> years (not eligible if < 18 years)
4. Sex	SSEX	<input type="checkbox"/> ₁ Female <input type="checkbox"/> ₂ Male
5.	Race/ethnicity	
	a.	Do you consider yourself Hispanic or Latino? <input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ Unknown SETHN
	b.	Race (check only one) SRACE
	<input type="checkbox"/> ₁ Native American or Alaska Native	<input type="checkbox"/> ₄ Black or African-American
	<input type="checkbox"/> ₂ Asian	<input type="checkbox"/> ₅ White
	<input type="checkbox"/> ₃ Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> ₆ Unknown or Not Reported

B. Current Medications

6.	Are you allergic to tamsulosin	SALLTAM	<input type="checkbox"/> ₀ No (or unknown) <input type="checkbox"/> ₁ Yes
7.	Do you take any medication on a regular basis?		<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes SMEDS
8.	If yes, list current medications	SMEDSX	
	_____		_____
	_____		_____
	_____		_____
	_____		_____

Patient is NOT ELIGIBLE if on insulin, oral hypoglycemics, or calcium channel blockers

C. Symptoms

9.	List symptoms	Check all that apply
<input type="radio"/>	a. Increased need to urinate	<div style="display: inline-block; text-align: right;">SURIN</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>
<input type="radio"/>	b. Urinating more often at night	<div style="display: inline-block; text-align: right;">SURNIGHT</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>
<input type="radio"/>	c. Pain when urinating	<div style="display: inline-block; text-align: right;">SPAINUR</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>
<input type="radio"/>	d. Feeling of not emptying bladder completely	<div style="display: inline-block; text-align: right;">SNOTEMP</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>
<input type="radio"/>	e. Side pain ('Flank' pain)	<div style="display: inline-block; text-align: right;">SSIDEP</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>
<input type="radio"/>	f. Nausea	<div style="display: inline-block; text-align: right;">SNAUSEA</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>
<input type="radio"/>	g. Vomiting	<div style="display: inline-block; text-align: right;">SVOMIT</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; text-align: center; vertical-align: middle;">1</div>

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<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto; display: flex; align-items: center; justify-content: center;">G</div> Site	Participant ID (Obtain from drug label)	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div>
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9. List symptoms (continued)		Check all that apply
○	h. Dizzy	SDIZZY <input type="checkbox"/>_1
○	i. Chest pain	SCHPAIN <input type="checkbox"/>_1
○	j. Fever	SFEVER <input type="checkbox"/>_1

D. Medical History (by report)		
10.	Past history of kidney stones? SHXKSTN <input type="checkbox"/>_0 No <input type="checkbox"/>_1 Yes If yes, SNUMSTN SDTSTN a. How many episodes? <input type="text"/> b. Date of most recent episode <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
11.	Family history of kidney stones (parents/siblings)?	SFAMHX <input type="checkbox"/>_0 No <input type="checkbox"/>_1 Yes
12.	Have you had a kidney transplant or donated a kidney?	STRANSP <input type="checkbox"/>_0 No <input type="checkbox"/>_1 Yes
13.	Have you had surgery for stones in the kidney or renal system?	SSURG <input type="checkbox"/>_0 No <input type="checkbox"/>_1 Yes

E. Initial Vital Signs		
Initial (recorded at triage)		
14.	Blood pressure	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> mmHg SIBPSYS / SIBPDIA
15.	Heart rate	<input type="text"/> <input type="text"/> <input type="text"/> bpm SIHR
16.	RR	<input type="text"/> <input type="text"/> SIRR
17.	Temperature SITEMP	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> °F (Patient not eligible if temp>101.5 °F)

F. Urine Results							
Urinalysis – dipstick:		SDIPGLUC		----	SDIPBLD	----	SDIPWBC
		0	Trace	1+	2+	3+	4+
18.	Glucose	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5
19.	Blood	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5
20.	White cells	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	<input type="checkbox"/> _5
21.	Was an HCG done? <input type="checkbox"/> _0 No or not indicated (e.g. hysterectomy, tubal ligation, post menopause or male) <input type="checkbox"/> _1 Yes if yes, record result below SHCG						
	a. If Yes, HCG result	SHCGRES		<input type="checkbox"/> _0 Negative <input type="checkbox"/> _1 Positive (not eligible)			
22.	Was Urinalysis microscopy done?	SMICRO		<input type="checkbox"/> _0 No (If No, skip to 26) <input type="checkbox"/> _1 Yes			
		none, negative, WNL	1-5, trace, present, slight, rare	6-15, moderate	16-30, many, frequent	> 30, innumerable, TNTC	
23.	Blood	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	SMICBLD
24.	White cells	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	SMICWBC
25.	Bacteria	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4	SMICBACT

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G. X-ray & CT scan results

For KUB:		
26. Was a KUB done? (if No, skip to 31)	RKUB	<input type="checkbox"/> No <input type="checkbox"/> Yes
27. Was a stone noted? RKSTONE	<input type="checkbox"/> No stone noted <input type="checkbox"/> Yes, one stone <input type="checkbox"/> Yes, multiple stones	
a. If Yes, largest dimension: <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> mm (not eligible if larger than 9mm) RKLARGST		
Report by radiologist (may be filled out later)		
28.	"Possible stone"? RKPOSS	<input type="checkbox"/> No <input type="checkbox"/> Yes
29.	Phlebolith? RKPHLEB	<input type="checkbox"/> No <input type="checkbox"/> Yes
30.	Bilateral stones? RKBILAT	<input type="checkbox"/> No <input type="checkbox"/> Yes
For CT scan:		
31.	Was a stone noted? RCTSTONE <input type="checkbox"/> No stone noted <input type="checkbox"/> Yes, one stone <input type="checkbox"/> Yes, multiple stones a. If Yes, largest dimension: <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> mm (not eligible if larger than 9mm) RLARGEST	
32.	Hydronephrosis? RHYDRON	<input type="checkbox"/> No <input type="checkbox"/> Yes
33.	Stranding? RSTRAND	<input type="checkbox"/> No <input type="checkbox"/> Yes
34.	Bilateral stones? RBILAT	<input type="checkbox"/> No <input type="checkbox"/> Yes
35.	Stone location Check all that apply if multiple stones	
	a. Renal pelvis RLRENPEL	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
	b. Proximal ureter RLPROXUR	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
	c. Mid ureter RLPROXUR	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
	d. Distal ureter RLDISTUR	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
	e. UVJ RLUVJ	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
	f. Bladder RLBLAD	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
	g. Location not specified RLNOTSPC	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">1</div>
36.	"Possible stone"? RCTPOSS	<input type="checkbox"/> No <input type="checkbox"/> Yes
37.	Phlebolith? RCTPHLEB	<input type="checkbox"/> No <input type="checkbox"/> Yes

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38.	Other CT findings	Check all that apply
	a. Appendicitis RCTAPPEN	<input type="checkbox"/> ₁
	b. Diverticulitis RCTDIVER	<input type="checkbox"/> ₁
	c. Inflammatory bowel disease RCTINFLA	<input type="checkbox"/> ₁
	d. Aortic aneurysm RCTAORT	<input type="checkbox"/> ₁
	e. Abdominal mass RCTABDO	<input type="checkbox"/> ₁
	f. Fibroids RCTFIBR	<input type="checkbox"/> ₁
	g. Pelvic mass RCTPELMS	<input type="checkbox"/> ₁
	h. Solitary kidney (if yes patient is not eligible) RCTSINGL	<input type="checkbox"/> ₁
	i. Other RCTOTHER i) Specify: <div style="border: 1px solid black; width: 300px; height: 20px; display: inline-block;"></div>	<input type="checkbox"/> ₁

H. Blood Tests and Results

39.	Was a CBC obtained?	SCBC	<input type="checkbox"/> ₀ No	If no, skip to 41	<input type="checkbox"/> ₁ Yes
40.	Were there any abnormalities?	SCBCABN	<input type="checkbox"/> ₀ No	If no, skip to 41	<input type="checkbox"/> ₁ Yes
	If Yes, CBC abnormalities:	Check all that apply			
	a. Raised WBC	SWBCABN	<input type="checkbox"/> ₁		
	b. Low WBC	SWBCABN	<input type="checkbox"/> ₁		
	c. Raised HCT	SHCTABN	<input type="checkbox"/> ₁		
	d. Low HCT	SHCTABN	<input type="checkbox"/> ₁		
	e. Raised platelets	SPLATABN	<input type="checkbox"/> ₁		
	f. Low platelets	SPLATABN	<input type="checkbox"/> ₁		

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41.	Was a blood chemistry obtained?	SCHEM	<input type="checkbox"/> ₀ No	If no, skip to 43	<input type="checkbox"/> ₁ Yes
42.	Were there any abnormalities?	SCHEMABN	<input type="checkbox"/> ₀ No	If no, skip to 43	<input type="checkbox"/> ₁ Yes
	If Yes, blood chemistry abnormalities:				Check all that apply
	a. Raised Na	SNAABN	<input type="checkbox"/> ₁		
	b. Low Na	SNAABN	<input type="checkbox"/> ₁		
	c. Raised K	SKABN	<input type="checkbox"/> ₁		
	d. Low K	SKABN	<input type="checkbox"/> ₁		
	e. Raised CO2	SCO2ABN	<input type="checkbox"/> ₁		
	f. Low CO2	SCO2ABN	<input type="checkbox"/> ₁		
	g. Raised BUN	SBUNABN	<input type="checkbox"/> ₁		
	h. Low BUN	SBUNABN	<input type="checkbox"/> ₁		
	i. Raised creatinine (if >2.6 in a male or 3.5 in a female, pt is not eligible)		<input type="checkbox"/> ₁		
	j. Low creatinine	SCRTABN	<input type="checkbox"/> ₁		
	k. Raised glucose	SGLUCABN	<input type="checkbox"/> ₁		
	l. Low glucose	SGLUCABN	<input type="checkbox"/> ₁		
I. Discharge from ED					
43.	Stone expelled in the ED?	SEXPEL	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes (If yes, not eligible)	
44.	Final primary ED diagnosis	SFINDX	<input type="checkbox"/> ₁ Renal colic	<input type="checkbox"/> ₂ Nephrolithiasis	<input type="checkbox"/> ₃ Other
	a. If Other, specify:	<div style="border: 1px solid black; width: 350px; height: 25px; margin: 0 auto;">SFINDXX</div>			
45.	Patient admitted?	SADMIT	<input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes (If yes, not eligible)	
	a. If yes , to which service?	SADMSERV	<input type="checkbox"/> ₁ Urology	<input type="checkbox"/> ₂ Surgery	<input type="checkbox"/> ₃ Medicine <input type="checkbox"/> ₄ Other
	i) If Other, specify:	<div style="border: 1px solid black; width: 350px; height: 25px; margin: 0 auto;">SADMSRVX</div>			

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Discharge vital signs (use last set recorded)			
46.	Blood pressure	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> / <div style="border: 1px solid black; width: 30px; height: 20px; display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> mmHg	SDBPSYS / SDBPDIA
47.	Heart rate	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> bpm	SDHR
48.	RR	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div>	SDRR
49.	Temperature	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 10px; height: 10px;"></div> </div> °F (Patient not eligible if temp>101.5 °F)	SDTEMP

**PLEASE ENSURE THAT ALL DATA AND RADIOLOGY RESULTS HAVE BEEN RECORDED
BEFORE COMPLETION OF THIS FORM**

**THE FOLLOWING CT SCAN QUESTIONS WERE NOT INCLUDED ON THE ORIGINAL FORM,
BUT WERE KEYED IN THE DATABASE FOLLOWING THE INITIAL ENTRY.**

For CT scan:			
	Side of symptomatic stone	RSIDESYM	<div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> 1 = Left 2 = Right
	Location of symptomatic stone	RLOCASYM	<div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> 1 = Renal Pelvis 2 = Proximal ureter 3 = Mid ureter 4 = Distal ureter 5 = UVJ
	Size of symptomatic stone	RSIZESYM	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 10px; height: 10px;"></div> </div> mm
	Side of additional stones	RSIDELOC	<div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 15px; height: 15px;"></div> </div> 1 = Left 2 = Right 3 = Bilateral

END OF FORM

STONE: FOLLOW-UP FORM

<div style="border: 1px solid black; padding: 2px; width: 30px; margin: 0 auto;">G</div> Site	Participant ID (Obtain from drug label) <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	Post ED Visit day NUMBER <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
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1.	Date of contact	FDATE	<div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
2.	Name of person completing this form _____	FINITS	Initials <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
3.	Was patient unable to be reached?	FREACH	<input type="checkbox"/> No <input type="checkbox"/> Yes

If question 3 is checked Yes, STOP.
If Day 90 contact, SKIP to question 8.

4.	Have you taken the study medication	FSTDYMED	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. How many doses since the last interview ?	FSMEDDOS	<div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
5.	Are you taking a NSAID?	FNSAID	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. What dose? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> mg	FNSDOS	
	b. How many pills have you taken since the last phone contact? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> pills	FNSNUM	
6.	Are you taking a Percocet?	FPERC	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. What dose? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> mg	FPERCDOS	
	b. How many pills have you taken since the last phone contact? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> pills	FPERCNUM	
7.	Are you taking another analgesic?	FANALG	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. Specify: <div style="border: 1px solid black; display: inline-block; width: 350px; height: 20px; text-align: center; margin: 0 10px;">FANALGX</div>		
	b. What dose? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> mg	FANDOS	
	c. How many pills have you taken since the last phone contact? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> pills	FANNUM	
8.	Are you employed?	FEMPLOYD	<input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes,		
	a. Have you returned to work?	FRETWORK	<input type="checkbox"/> No <input type="checkbox"/> Yes
9.	Have you noted any of the following?		
	a. Feeling dizzy (any time)	FDIZZY	<input type="checkbox"/> No <input type="checkbox"/> Yes
	b. Feeling dizzy on standing up	FDIZSTND	<input type="checkbox"/> No <input type="checkbox"/> Yes
	c. Burning, stinging when urinating or needing to urinate more often?		<input type="checkbox"/> No <input type="checkbox"/> Yes FURINATE
	d. Abnormalities of ejaculation	FABNEJAC	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA- female patient

STONE: FOLLOW-UP FORM

<div style="border: 1px solid black; padding: 2px; width: 30px; margin: 0 auto;">G</div> Site	Participant ID (Obtain from drug label) <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	Post ED Visit day NUMBER <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>
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10.	Have you had a follow-up visit with a doctor for the stone?	FFUPVST	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, a. Name of MD: _____ b. Phone (if possible) _____ c. Date of visit <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> FFUPDATE <div style="text-align: center;">FFUPSPEC</div> d. Specialty: <input type="checkbox"/> PCP <input type="checkbox"/> Urologist <input type="checkbox"/> Other i) If other, specify <div style="border: 1px solid black; display: inline-block; padding: 2px; width: 150px;">FFUPSPCX</div>			
11.	Have you returned to the ER because of the stone?	FRETER	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, a. Which ER? _____ b. Date of visit <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> FERDATE c. Did you have any of these procedures? <input type="checkbox"/> No <input type="checkbox"/> Yes -x-rays <input type="checkbox"/> Yes -CT FERXRAY FERCT d. Give brief narrative of reason for visit and outcome below:			
12.	Have you been hospitalized because of the stone?	FHOSP	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, a. Which hospital? _____ b. Date of hospitalization <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> FHSPDATE c. How many nights did you spend in the hospital? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> nights FHSPNITE d. Give brief narrative of reason for visit and outcome below:			
13.	Have you expelled the stone?	FEXPEL	<input type="checkbox"/> No <input type="checkbox"/> Seen <input type="checkbox"/> Captured
If Seen or Captured, a. Date <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> / <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> FEXPDATE			
14.	Have you had or been scheduled for surgical intervention for stone?	FSURG	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, a. Type of procedure FSURGTYP <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Ureteral stent <input type="checkbox"/> Ureterscopy (no stent) <input type="checkbox"/> Other i) If Other, specify type: <div style="border: 1px solid black; display: inline-block; padding: 2px; width: 150px;">FSRGTYPX</div>			

END OF FOLLOW UP FORM