

Standard Visit Inventory

Patient ID: _____
 Patient Initials: _____
 Clinical Center: _____
 Contact Week: _____
 Date: ____ / ____ / ____
month day year
 RC ID: _____

(Research Coordinator completed at weeks 3, 10, 17, 24 and post treatment follow-up, if applicable.)

1. ***Is this the week number 3 visit?***

☐₁ Yes ☐₀ No

If YES, skip to Part Two. If NO, continue.

Part One: COMPLIANCE

2. Date of last clinic visit

Date: ____ / ____ / ____
month day year

Column: A	B	C	D	E	F
Amount Dispensed at last visit	Amount Returned	Amount Lost/ Destroyed	How many were used? A - (B + C)	How many should have been taken?	Percent Compliance (D / E) x 100
<i>Green Capsules:</i> _____	()	()	().	()	3. _____ %
<i>White Capsules:</i> _____	()	()	()	()	4. _____ %

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Part Two: DISPENSING (Record on Study Medication Tracking Log)

5. Total number of **green** capsules dispensed today:

Week # ___ to ___

*Peel label off bottle dispensed and apply here:
(Record on Study Medication Tracking Log)*

For Post Treatment Follow-up Phase only:
*Peel label off **second bottle** dispensed and apply here:
(Record on Study Medication Tracking Log)*

6. Total number of **white** capsules dispensed today:

Week # ___ to ___

*Peel label off bottle dispensed and apply here:
(Record on Study Medication Tracking Log)*

For Post Treatment Follow-up Phase only:
*Peel label off **second bottle** dispensed and apply here:
(Record on Study Medication Tracking Log)*

Part Three: ADVERSE EVENTS

7. Since your last scheduled clinic contact, have you had any adverse experiences, abnormal laboratory values, hospitalizations, discontinued medications due to side effects, other complications or pre-existing conditions that worsened? ☐₁ Yes ☐₀ No

If **YES**, an Adverse Event Report **MUST** be completed
(except for known ADRs).

8. Have you either initiated or increased your narcotic drug usage since your last scheduled clinic contact? ☐₁ Yes ☐₀ No

If **YES**, this must be recorded on the patient's Daily Medication Diary.

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Part Four: MEDICATION UPDATE

9. Since your last scheduled clinic contact, have you taken any of the following?
(See "Exclusionary and Restricted Medications" table and MOP)

- | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----|---------------------------------------|----|
| a. Tagamet® (cimetidine)
<i>(If YES, the patient must be taken off the study.)</i> | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No |
| b. Intravesical heparin
<i>(If YES, the patient must be taken off the study.)</i> | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No |
| c. Use of more than one gram of aspirin per day for more than three days out of seven?
(Bayer®, Anacin®, Excedrin®)
<i>If YES, this must be reflected on the patient's Daily Medication Diary.</i> | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No |
| d. Use of more than one maximum allowable dose per day of acetaminophin or aspirin replacement products (NSAIDs) for more than three days out of seven? (Motrin®, Advil®)
<i>If YES, this must be reflected on the patient's Daily Medication Diary.</i> | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No |
| e. Use of products that contain brompheniramine, diphenhydramine, or chlorpheniramine for more than three days out of seven (except for isolated incidences such as for a "cold")? (Benadryl®, Dimetane®)
<i>If YES, this must be reflected on the patient's Daily Medication Diary.</i> | <input type="checkbox"/> ₁ | Yes | <input type="checkbox"/> ₀ | No |

Part Five: IC TREATMENT UPDATE

10. Since your last scheduled clinic contact, have you started any of the following treatments for your IC? ☐₁ Yes ☐₀ No

If **YES**, indicate as many as apply below:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No hydrodistentions
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No bladder instillations
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No biofeedback/mind-body techniques
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No chiropractic treatment
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No accupuncture/accupressure
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No bladder holding/retraining therapy
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No pain clinic
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No peripheral or central electrical stimulation | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No psychotherapy
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No pelvic floor therapies
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No massage therapy
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No homeopathy and/or herbs
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No L-arginine
<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No other, specify: _____

_____ |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|