

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

(Patient Completed at Baseline 2 and weeks 3, 10, 17, 24, and post treatment follow-up)

Please circle the one number answer that comes closest to the way you feel, whether or not you have the following symptoms.

Symptom		Not At All	(Circle one number on each line)					A Lot
1.	Bladder Discomfort	0	1	2	3	4	5	6
2.	Bladder Pain	0	1	2	3	4	5	6
3.	Other Pelvic Discomfort	0	1	2	3	4	5	6
4.	Headache	0	1	2	3	4	5	6
5.	Backache	0	1	2	3	4	5	6
6.	Dizziness	0	1	2	3	4	5	6
7.	Feelings of Suffocation	0	1	2	3	4	5	6
8.	Chest Pain	0	1	2	3	4	5	6
9.	Ringing in Ears	0	1	2	3	4	5	6
10.	Getting Up at Night to Go to the Bathroom	0	1	2	3	4	5	6
11.	Aches in Joints	0	1	2	3	4	5	6
12.	Swollen Ankles	0	1	2	3	4	5	6
13.	Nasal Congestion	0	1	2	3	4	5	6
14.	Flu	0	1	2	3	4	5	6
15.	Abdominal Cramps	0	1	2	3	4	5	6
16.	Numbness or Tingling in Fingers or Toes	0	1	2	3	4	5	6
17.	Nausea	0	1	2	3	4	5	6
18.	Going to the Bathroom frequently during the day	0	1	2	3	4	5	6
19.	Blind Spots or Blurred Vision	0	1	2	3	4	5	6
20.	Heart Pounding	0	1	2	3	4	5	6
21.	Difficulty Sleeping because of Bladder Symptoms	0	1	2	3	4	5	6
22.	Sore Throat	0	1	2	3	4	5	6
23.	Urgency to Urinate	0	1	2	3	4	5	6
24.	Coughing	0	1	2	3	4	5	6
25.	Burning Sensation in Bladder	0	1	2	3	4	5	6