

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

(Research Coordinator completed at weeks 1, 2, 3, 6, 14 and 20)

1. How many white capsules are you currently taking every 24 hours?

☐₀ 0 (none)
☐₁ 1
☐₂ 2
☐₃ 3
☐₄ more than 3

2. How many green capsules are you currently taking every 24 hours?

☐₀ 0 (none)
☐₁ 1
☐₂ 2
☐₃ more than 2

Part One: ADVERSE EVENTS

3. 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)*

4. 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.*

Part Two: MEDICATION UPDATE

5. Since your last scheduled clinic contact, have you taken any of the following . . . ?

(See “Exclusionary and Restricted Medications” table and MOP)

a. Tagamet® (cimetidine) ☐₁ Yes ☐₀ No
(If YES, the patient must be taken off the study.)

b. Intravesical heparin ☐₁ Yes ☐₀ No
(If YES, the patient must be taken off the study.)

c. Use of more than one gram of aspirin per day for more than three days out of seven? ☐₁ Yes ☐₀ No
(Bayer®, Anacin®, Excedrin®)

If YES, this must be reflected on the patient’s Daily Medication Diary.

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®) ☐₁ Yes ☐₀ No

If YES, this must be reflected on the patient’s Daily Medication Diary.

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®) ☐₁ Yes ☐₀ No

If YES, this must be reflected on the patient’s Daily Medication Diary.

Part Three: IC TREATMENT UPDATE

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

If **YES**, have you had . . . ?

- | | | |
|--|---|--|
| 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 below: | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No |

FEMALES ONLY: (Indicate n/a, for males and for females not of childbearing potential.)

7. What was the date of onset of your most recent menstrual period? Date: _____ / _____ / _____
month day year

☐₉ Not applicable