

Medical History

Patient ID: _____
 Patient Initials: _____
 Clinical Center: _____
 Contact Week: 0
 Date: ____ / ____ / ____
 month day year
 RC ID: _____

(Patient Interview completed at Baseline 1 visit)

I'm going to ask you some questions . . .

1. How old were you when your urinary symptoms first began?

_____ age

☐_8 unknown

2. How old were you when your interstitial cystitis (IC) was diagnosed by a doctor?

_____ age

☐_8 unknown

3. Have you ever received treatment for IC?

☐_1 Yes ☐_0 No

- a. If **YES**, have you had any of the following treatments?

Drug	<input type="checkbox"/> _1 Yes	<input type="checkbox"/> _0 No
Behavioral	<input type="checkbox"/> _1 Yes	<input type="checkbox"/> _0 No
Dietary	<input type="checkbox"/> _1 Yes	<input type="checkbox"/> _0 No
Surgical	<input type="checkbox"/> _1 Yes	<input type="checkbox"/> _0 No
Intravesical	<input type="checkbox"/> _1 Yes	<input type="checkbox"/> _0 No

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I am going to ask you some questions about some medical disorders and conditions.

Have you ever been *diagnosed* as having . . . ?

Genito-Urinary Disorders: (Both Women and Men)

- | | | | | |
|----|----------------------------------|---|--|---|
| 4. | Urinary Incontinence | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 5. | Kidney Stones or Urinary Stones | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 6. | Any sexually transmitted disease | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 7. | Childhood bladder problems | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 8. | Urinary tract infection | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |

Women Only

- | | | | | | |
|-----|-----------------------------------|---|--|---|---|
| 9. | Pelvic Inflammatory Disease (PID) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown | <input type="checkbox"/> ₉ n/a |
| 10. | Endometriosis | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown | <input type="checkbox"/> ₉ n/a |
| 11. | Vulvodynia | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown | <input type="checkbox"/> ₉ n/a |

Men Only

- | | | | | | |
|-----|------------------------------------|---|--|---|---|
| 12. | Benign Prostatic Hyperplasia (BPH) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown | <input type="checkbox"/> ₉ n/a |
| 13. | Prostatitis | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown | <input type="checkbox"/> ₉ n/a |

Respiratory Tract Disorders/Allergies: (Both Women and Men)

- | | | | | |
|-----|----------------|---|--|---|
| 14. | Asthma | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 15. | Drug allergies | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 16. | Food allergies | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |

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- | | | | | |
|-----|-------------------------------------|---|--|---|
| 17. | Skin allergies (contact dermatitis) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 18. | Sinusitis | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 19. | Hayfever, allergic rhinitis | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 20. | Latex allergies | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |

Other Disorders: (Both Women and Men)

- | | | | | |
|-----|---|---|--|---|
| 21. | Diabetes | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 22. | Fibromyalgia or Fibromyositis | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 23. | Chronic Fatigue Syndrome | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 24. | Irritable Bowel Syndrome | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 25. | Autoimmune Disorders (for example, Lupus, Rheumatoid Arthritis, Sjogren's, Scleroderma) | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 26. | Lumbosacral/Vertebral Disc Disease | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
| 27. | Migraine Headaches | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |

Now I am going to ask some questions about some surgeries that you may have had.

Have you ever had . . . ?

Bladder/Urinary Tract Surgeries, such as . . . (Both Women and Men)

- | | | | | |
|-----|----------------------------|---|--|---|
| 28. | Cystoscopy/Hydrodistention | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈ Unknown |
|-----|----------------------------|---|--|---|

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Contact Week: 029. Incontinence surgery ☐₁ Yes ☐₀ No ☐₈ Unknown30. Other bladder surgery (such as diverticulectomy) ☐₁ Yes ☐₀ No ☐₈ Unknown

Gynecologic Surgeries - Women Only

31. Cystocele repair (bladder hernia) ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a32. Rectocele repair (rectal hernia) ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a33. Enterocele repair (intestinal hernia) ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a34. Laparoscopy ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a35. D&C/D&E ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a36. Hysterectomy ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a37. Tubal Ligation ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a38. Removal of one or both ovaries ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a

Other Surgeries: (Both Women and Men)

39. Inguinal hernia repair ☐₁ Yes ☐₀ No ☐₈ Unknown40. Other abdominal or pelvic surgery ☐₁ Yes ☐₀ No ☐₈ Unknown41. Back Surgery ☐₁ Yes ☐₀ No ☐₈ Unknown

Men Only

42. Prostate surgery (for benign disease) ☐₁ Yes ☐₀ No ☐₈ Unknown ☐₉ n/a