

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

(This form is completed when the patient stops taking the study medication (if prior to week 24) and at the week 24 visit.)

(Patient completes questions #1, 2, 3 and 4.)

Check only one box for each question.

1. As compared to when you started the study, how would you rate your overall symptoms now?

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
Markedly Worsened	Moderately Worsened	Slightly Worsened	No Change	Slightly Improved	Moderately Improved	Markedly Improved

2. Do you think the current status of your symptoms is related to the study medication?

☐₁ Yes

☐₀ No

3. Which medication do you think you were on?

☐₁ Couldn't tell
☐₂ Hydroxyzine
☐₃ Elmiron®
☐₄ Hydroxyzine/Elmiron®
☐₅ Placebo

4. Refer to your answer to question #3. What made you think that?

☐₁ IC was better
☐₂ IC was worse
☐₃ IC remained unchanged
☐₄ appearance of capsules
☐₅ taste of capsules
☐₆ experienced side effects
☐₇ did not experience side effects
☐₈ other, specify: _____

Patient Close-out

Patient ID: ____

Contact Week: ____

(Research Coordinator completes question #5.)

5. Which medication does the Research Coordinator think the patient was on?

- ☐₁ Couldn't tell
- ☐₂ Hydroxyzine
- ☐₃ Elmiron®
- ☐₄ Hydroxyzine/Elmiron®
- ☐₅ Placebo