CPCRN CHRONIC PROSTATITIS COHORT

Concomitant Medications

Patient ID: 1 ___ ___ ___ ___
Patient Initials: ___ ___ ___
Clinical Center: ___
Contact Month: ___ 0
Date: ___ ___ / ___ ___ / ___ ___
month day year
RC ID: ___ ___ ___ ___

(Patient Interview Completed)

Please indicate if you currently use any of the following medications.

1.	Cold Medicine (OTC or prescription)	❑1 Yes	❑0 No	❑8 Unknown
2.	Anti-hypertensives	❑1 Yes	❑0 No	❑8 Unknown
3.	Anti-psychotics	❑1 Yes	❑0 No	❑8 Unknown
4.	Cardiac medication	❑1 Yes	❑0 No	❑8 Unknown
5.	Testosterone replacement therapy	❑1 Yes	❑0 No	❑8 Unknown
6.	Migraine medication	❑1 Yes	❑0 No	❑8 Unknown
7.	H_2 Blockers	❑1 Yes	❑0 No	❑8 Unknown
8.	Other	❑1 Yes	❑0 No	❑8 Unknown

Please specify: _____