C P C R N	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: ____

C P C R N	CHRONIC PROSTATITIS COHORT	Patient Completion	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Last Contact Month: ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month day year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

This form is to be completed at the time of the study's close-out processes for every patient in the CPC study.

1. Has the patient completed the CPC study? ❑1 Yes ❑0 No

Signatures

I verify that all information collected on the CPCRN CPC data collection forms for this patient has been reviewed and is correct to the best of my knowledge, and was collected in accordance with the procedures outlined in the CPCRN CPC Protocol and Manual of Procedures.

2. Research Coordinator's signature:

____

Research Coordinator's ID: ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month day year)

3. Principal Investigator's signature:

____

Principal Investigator's ID: ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month day year)

CPCRN	CHRONIC PROSTATITIS COHORT	Deferral Checklist	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

1. Has the patient been treated with antimicrobial agents (oral or parenteral) in the past three months? ❑1 Yes ❑0 No

2. Has the patient had a urinary tract infection with a urine culture value of >100,000 CFU/ml within the past three months? ❑1 Yes ❑0 No

3. Has the patient had any of the following sexually transmitted diseases (STDs) in the past three months:

   3a. Gonorrhea ❑1 Yes ❑0 No

   3b. Chlamydia ❑1 Yes ❑0 No

   3c. Mycoplasma ❑1 Yes ❑0 No

   3d. Trichomonas ❑1 Yes ❑0 No

4. Has the patient had a prostate biopsy in the past three months? ❑1 Yes ❑0 No

5. Has the patient experienced symptoms of acute or chronic epididymitis within the past three months? ❑1 Yes ❑0 No

6. Has the patient been diagnosed with or treated for symptomatic genital herpes in the past twelve months? ❑1 Yes ❑0 No

7. Is the patient eligible for the study at this time? ❑1 Yes ❑0 No

   If any of the shaded boxes are filled in, the patient must be deferred.

☞ If ***Yes***, please continue with the screening process.

☞ If ***No,*** please indicate the date the patient will be eligible. ___ ___ / ___ ___ / ___ ___ (month / day / year)

C P C R N

CHRONIC PROSTATITIS COHORT

Epidemiologic History

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

(Patient Completed)

1. What is your date of birth? ___ ___ / ___ ___ / ___ ___ ___ ___ (month / day / year)

2. How do you describe yourself?
   - ❑1 Asian or Pacific Islander
   - ❑2 Black/African-American (not Latino/Hispanic)
   - ❑3 Latino/Hispanic/ Mexican-American
   - ❑4 Native American
   - ❑5 White/Caucasian (not Latino/Hispanic)
   - ❑6 Multiracial
   - ❑7 Other

3. What is the highest educational level you have attained?
   - ❑1 Less than high school
   - ❑2 High school or GED
   - ❑3 Some college/university
   - ❑4 Graduated from college/university
   - ❑5 Graduate or professional school after college/university

4. Are you living with a spouse or partner? ❑1 Yes ❑0 No

5. What is your current employment status?
   - ❑1 Employed
   - ❑2 Unemployed
   - ❑3 Retired
   - ❑4 Disabled

6a. ***For US residents***, what is your annual family income (in US dollars)?

- ❑1 $10,000 or less
- ❑2 $10,001 to $25,000
- ❑3 $25,001 to $50,000
- ❑4 $50,001 to $100,000
- ❑5 More than $100,000

6b. ***For Canadian residents***, what is your annual family income (in Canadian dollars)?

- ❑1 $15,000 or less
- ❑2 $15,001 to $30,000
- ❑3 $30,001 to $45,000
- ❑4 $45,001 to $75,000
- ❑5 More than $75,000

7a. ***For US residents***, what is your primary current insurance plan?

- ❑1 Fee-for-service
- ❑2 Medicare only
- ❑3 Medicaid only
- ❑4 Medicare and Medicaid
- ❑5 Medicare and supplemental
- ❑6 HMO/POS
- ❑7 Medicare/HMO
- ❑8 Medicaid/HMO
- ❑9 VA/CHAMPUS
- ❑10 PPO
- ❑11 Self-pay
- ❑12 Other

7b. ***For Canadian residents***, do you have insurance in addition to your provincial medical plan?

❑1 Yes ❑0 No

8. What is your ZIP/Postal code (US or Canadian)? ____________________

9. Have any family members ever been diagnosed with chronic pelvic pain or prostatitis? ❑1 Yes ❑0 No

10. Have any family members ever been diagnosed with interstitial cystitis (IC)? ❑1 Yes ❑0 No

11. What is your smoking status?
❑1 Never smoked
❑2 Current smoker
❑3 Former smoker

12. Do you currently drink alcoholic beverages? ❑1 Yes ❑0 No

If ***Yes***, approximately how many drinks per week do you have? ___ ___

13. Do you currently drink caffeinated beverages? ❑1 Yes ❑0 No

If ***Yes***, approximately how many cups of caffeinated beverage do you drink per day (cup of coffee, tea, caffeinated soda)? ___ ___

14. Are there trigger agents for your prostatitis symptoms? ❑1 Yes ❑0 No

If ***Yes***, what do you consider to be trigger agents for your prostatitis symptoms?
____
____
____
____
____
____
____

15. How were you referred to the CPC Study?
❑1 Urologist for this study
❑2 Other urologist
❑3 Other non-urology physician
❑4 Newspaper
❑5 Internet
❑6 Other

Sexual History

16. Have you ever had sexual intercourse (not including masturbation or oral sex)? ❑1 Yes ❑0 No

    If ***Yes***, how old were you when you first had sexual intercourse? ___ ___

17. Approximately how many sexual partners have you had in your lifetime? ___ ___ ___

18. With whom do you typically have sexual intercourse?
    - ❑1 Women exclusively
    - ❑2 Men exclusively
    - ❑3 Men and women
    - ❑4 No sexual intercourse

19. In which of the following types of sexual activities do you participate?

19a.	Masturbation	❑1 Yes	❑0 No
19b.	Vaginal intercourse	❑1 Yes	❑0 No
19c.	Anal intercourse as inserting partner	❑1 Yes	❑0 No
19d.	Anal intercourse as receiving partner	❑1 Yes	❑0 No
19e.	Oral sex performed on you	❑1 Yes	❑0 No

20. Do you use a birth control method or STD (sexually transmitted disease) protection? ❑1 Yes ❑0 No

If ***Yes***,

20a. Which of the following methods of birth control or STD protection do you use?

20a1.	Oral birth control pills used by partner	❑1 Yes ❑0 No
20a2.	Male/female condom	❑1 Yes ❑0 No
20a3.	Diaphragm used by partner	❑1 Yes ❑0 No
20a4.	Spermicide used by partner	❑1 Yes ❑0 No
20a5.	Vasectomy/tubal ligation	❑1 Yes ❑0 No

20b. How frequently do you use birth control or STD protection?
- ❑1 All of the time
- ❑2 More than half of the time
- ❑3 Half of the time
- ❑4 Less than half of the time

21. Have you ever had a sexually transmitted disease? ❑1 Yes ❑0 No

If ***Yes***, which of the following have you had?

21a.	Gonorrhea	❑1 Yes ❑0 No
21b.	Non-specific urethritis, such as chlamydia	❑1 Yes ❑0 No
21c.	Trichomonas	❑1 Yes ❑0 No
21d.	HIV/AIDS	❑1 Yes ❑0 No
21e.	Genital herpes	❑1 Yes ❑0 No
21f.	Other	❑1 Yes ❑0 No

22. Has your partner been diagnosed with any of the following in the past three months?

22a.	Urinary tract infection	❑1 Yes	❑0 No	❑9 N/A
22b.	Vaginitis	❑1 Yes	❑0 No	❑9 N/A
22c.	Gonorrhea	❑1 Yes	❑0 No	❑9 N/A
22d.	Trichomonas	❑1 Yes	❑0 No	❑9 N/A
22e.	Chlamydia	❑1 Yes	❑0 No	❑9 N/A
22f.	HIV/AIDS	❑1 Yes	❑0 No	❑9 N/A

C P C R N — CHRONIC PROSTATITIS COHORT

Physical Exam

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

(Principal Investigator Completed)

Examiner ID: ___ ___ ___ ___

1. Height — ___ ___ ___ . ___ inches
   Enter either inches or cm. — ___ ___ ___ . ___ cm

2. Weight — ___ ___ ___ ___ . ___ lbs
   Enter either lbs. or kgs. — ___ ___ ___ ___ . ___ kgs

3. Abdomen
   - ❑ 1 Normal
   - ❑ 2 Mass
   - ❑ 3 Organomegaly

   3a. Abdominal tenderness
   - ❑ 0 No
   - ❑ 1 Yes

4. Flanks
   - ❑ 1 Normal
   - ❑ 2 Mass

   4a. Flank tenderness
   - ❑ 0 No
   - ❑ 1 Yes

5. Varicocele
   - ❑ 1 Absent
   - ❑ 2 Present

   5a. Varicocele tenderness
   - ❑ 0 No
   - ❑ 1 Yes

6. Hydrocele
   - ☐ $_1$ Absent
   - ☐ $_2$ Present

   6a. Hydrocele tenderness
   - ☐ $_0$ No
   - ☐ $_1$ Yes

7. Inguinal Hernia
   - ☐ $_1$ Absent
   - ☐ $_2$ Present

   7a. Inguinal hernial tenderness
   - ☐ $_0$ No
   - ☐ $_1$ Yes

8. Is there any tenderness in the following areas?

   8a. Coccyx
   - ☐ $_0$ No
   - ☐ $_1$ Yes

   8b. Pubis
   - ☐ $_0$ No
   - ☐ $_1$ Yes

   8c. Suprapubic area
   - ☐ $_0$ No
   - ☐ $_1$ Yes

   8d. External pelvic floor (perineum)
   - ☐ $_0$ No
   - ☐ $_1$ Yes

   8e. Internal pelvic floor (side walls)
   - ☐ $_0$ No
   - ☐ $_1$ Yes

   8f. Cord/inguinal area
   - ☐ $_0$ No
   - ☐ $_1$ Yes

	Physical Exam	Patient ID: 1 ___ ___ ___ ___ Contact Month: ___ ___

Prostate Exam

9. Size — ☐1 Normal ☐2 Enlarged

10. Consistency — ☐1 Normal ☐2 Firm ☐3 Soft

11. Nodularity, irregularity, or asymmetry — ☐0 No ☐1 Yes

12. Prostatic tenderness — ☐0 No ☐1 Yes

Genitalia

13. Foreskin — ☐1 Normal ☐2 Absent ☐3 Abnormal

14. Glans — ☐1 Normal ☐2 Abnormal

15. Epididymes — ☐1 Normal ☐2 Abnormal

    15a. Epididymal tenderness — ☐0 No ☐1 Yes

16. Testes — ☐1 Normal ☐2 Abnormal

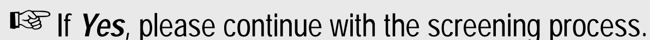
    16a. Testicular tenderness — ☐0 No ☐1 Yes

C P C R N	CHRONIC PROSTATITIS COHORT	Exclusion Checklist	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

1.	Does the patient have a history of prostate, bladder, or urethral cancer?	☐ 1 Yes	☐ 0 No
2.	Does the patient have inflammatory bowel disease (such as Crohn's disease or ulcerative colitis, but not irritable bowel syndrome)?	☐ 1 Yes	☐ 0 No
3.	Has the patient undergone pelvic radiation or systemic chemotherapy?	☐ 1 Yes	☐ 0 No
4.	Has the patient undergone intravesical chemotherapy?	☐ 1 Yes	☐ 0 No
5.	Has the patient been treated with intravesical BCG?	☐ 1 Yes	☐ 0 No
6.	Does the patient have unilateral orchialgia without pelvic symptoms?	☐ 1 Yes	☐ 0 No
7.	Does the patient have an active urethral stricture?	☐ 1 Yes	☐ 0 No
8.	Does the patient have a neurological disease or disorder affecting the bladder?	☐ 1 Yes	☐ 0 No
9.	Has the patient undergone TURP, TUIP, TUIBN, TUMT, TUNA, balloon dilatation of the prostate, open prostatectomy, or any other prostate surgery or treatment such as cryotherapy or thermal therapy?	☐ 1 Yes	☐ 0 No
10.	Does the patient have a neurological impairment or psychiatric disorder preventing his understanding of consent and his ability to comply with the protocol?	☐ 1 Yes	☐ 0 No

11.	Is the patient eligible for the study? ***If any of the shaded boxes are filled in, the patient is NOT eligible.***	☐ 1 Yes	☐ 0 No


☞ If ***Yes***, please continue with the screening process.

CPCRN	CHRONIC PROSTATITIS COHORT	Four Glass Test Microscopy	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

1. Has the patient remained abstinent for the past 48 hours?
   - ☐ 1 Yes
   - ☐ 0 No

VB1

2. White Blood Cell Count (/hpf)
   - ☐ 1 ≤ 25
   - ☐ 2 > 25

   If ≤ 25, give actual count ___ ___ /hpf

3. Red Blood Cell Count (/hpf)
   - ☐ 1 ≤ 25
   - ☐ 2 > 25

   If ≤ 25, give actual count ___ ___ /hpf

4. Yeast
   - ☐ 1 Absent
   - ☐ 2 Present

VB2

5. White Blood Cell Count (/hpf)

☐$_1$ ≤ 25
☐$_2$ > 25

If ≤ 25, give actual count ___ ___ /hpf

6. Red Blood Cell Count (/hpf)

☐$_1$ ≤ 25
☐$_2$ > 25

If ≤ 25, give actual count ___ ___ /hpf

7. Yeast

☐$_1$ Absent
☐$_2$ Present

8. pH

☐$_1$ 5.0
☐$_2$ 5.5
☐$_3$ 6.0
☐$_4$ 6.5
☐$_5$ 7.0
☐$_6$ 7.5
☐$_7$ 8.0

9. Glucose (mg/dl)

☐$_1$ 0
☐$_2$ 100
☐$_3$ 250
☐$_4$ 500
☐$_5$ 1000
☐$_6$ 2000

10. Protein (mg/dl)

☐$_1$ Negative
☐$_2$ Trace
☐$_3$ 30 (+)
☐$_4$ 100 (++)
☐$_5$ 300 (+++)
☐$_6$ ≥ 2000 (++++)

EPS

11. Estimated volume of EPS sample
    - ❑1 None
    - ❑2 1 to 2 drops
    - ❑3 3 or more drops

    If ***None***, go directly to question #18.

12. White Blood Cell Count (/hpf)
    - ❑1 ≤ 25
    - ❑2 26 - 50
    - ❑3 51-75
    - ❑4 76-100
    - ❑5 >100

    If ≤ 25, give actual count ___ ___ /hpf

13. Macrophage
    - ❑1 Absent
    - ❑2 Present

    If ***present***, give actual count ___ ___ /hpf

14. Red Blood Cells
    - ❑1 Absent
    - ❑2 Present

15. Yeast
    - ❑1 Absent
    - ❑2 Present

16. Sperm
    - ❑1 Absent
    - ❑2 Present

17. Was there any remaining EPS sample sent to lab for storage?
    - ❑1 Yes
    - ❑0 No

    If ***Yes***, date EPS sample sent to lab for storage ___ ___ / ___ ___ / ___ ___ (month / day / year)

VB3

18. Was a VB3 sample collected?
    - ❑1 Yes
    - ❑0 No

    If ***Yes***, continue,

19. White Blood Cell Count (/hpf)
    - ❑1 ≤ 25
    - ❑2 > 25

    If ≤ 25, give actual count ___ ___ (/hpf)

20. Red Blood Cell Count (/hpf)
    - ❑1 ≤ 25
    - ❑2 > 25

    If ≤ 25, give actual count ___ ___ /hpf

21. Yeast
    - ❑1 Absent
    - ❑2 Present

22. Prostate fluid form elements (e.g. fat bodies)
    - ❑1 Absent
    - ❑2 Present

C P C R N	CHRONIC PROSTATITIS COHORT	Four Glass Test Specimen Cultures	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

The table below lists the specimens to be identified in each sample, and each specimen's appropriate code. Use these codes when completing the tables for the culture count for each specimen.

Specimen	Specimen Code
Staphylococcus Epidermidis	01
Staphylococcus Aureus	02
Staphylococcus Other	03
Streptococcus Viridans	04
Staphylococcus Hemolyticus	05
Streptococcus Other	06
Enterococcus Fecalis	07
Corynebacterium	08
Escherichia Coli	09
Klebsiella	10
Pseudomonas	11
Proteus	12
Other	13

48 Hour Culture Count

1. Date of 48 hour count ___ ___ / ___ ___ / ___ ___ (month / day / year)

<u>VB1</u> - 48 hours

2. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

<u>VB2</u> - 48 hours

3. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

EPS - 48 hours

4. Was the patient able to provide an EPS sample? ❑1 Yes ❑0 No

If ***Yes***, continue on to question #5.
If ***No***, go to question #6.

5. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

VB3 - 48 hours

6. Was a VB3 sample collected? ❑1 Yes ❑0 No

If ***Yes***, continue on to question #7.
If ***No***, go to question #8.

7. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

5 Day Culture Count

8. Date of 5 day count ___ ___ / ___ ___ / ___ ___ (month / day / year)

VB1 - 5 days

9. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

VB2 - 5 days

10. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

EPS - 5 days

11. Was the patient able to provide an EPS sample? ❑1 Yes ❑0 No

If ***Yes***, continue on to question #12.
If ***No***, go to question #13.

12. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

VB3 - 5 days

13. Was a VB3 sample collected? ❑1 Yes ❑0 No

If ***Yes***, continue on to question #14.

14. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml
___ ___	❑1 <100,000 ❑2 ≥100,000	___ ___ ___ ___ ___ CFU/ml

C P C R N

CHRONIC PROSTATITIS COHORT

Interim Health Care

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

(Patient Interview Completed)

1. In the past six months, how many times have you visited a physician for your prostatitis symptoms? ___ ___

2. Have you been admitted to the hospital for any reason in the past six months? ❑ 1 Yes ❑ 0 No

   If ***Yes***, please describe the reason:
   ____
   ____
   ____
   ____

3. In the past six months, how many days have you missed work due to your prostatitis or associated symptoms, including health care appointments and sick days. ___ ___ ___ days

4. During the past six months, what were your estimated out of pocket costs for your prostatitis-related symptoms and treatments (do not include insurance premiums). ___ ___ ___ ___ ___ dollars

5. Are you living with a spouse or partner? ❑ 1 Yes ❑ 0 No

6. Please indicate if any of the following occurred in the past six months. (These are the original screening **exclusion** criteria, but they do not exclude the patient at this time.)

6a.	Prostate, bladder, or urethral cancer	❑1 Yes	❑0 No
6b.	Inflammatory bowel disease	❑1 Yes	❑0 No
6c.	Pelvic radiation or systemic chemotherapy	❑1 Yes	❑0 No
6d.	Intravesical chemotherapy	❑1 Yes	❑0 No
6e.	Intravesical BCG	❑1 Yes	❑0 No
6f.	Unilateral orchialgia without pelvic symptoms	❑1 Yes	❑0 No
6g.	Active urethral stricture	❑1 Yes	❑0 No
6h.	Neurological disease or disorder affecting the bladder	❑1 Yes	❑0 No
6i.	TURP, TUIP, TUIBN, TUMT, TUNA, balloon dilatation, radical prostatectomy, or cryotherapy or chemotherapy	❑1 Yes	❑0 No
6j.	Neurological impairment or psychiatric disorder	❑1 Yes	❑0 No

7. Please indicate if any of the following occurred in the past six months. (These are the original screening **deferral** criteria, but they do not defer the patient at this time.)

7a.	Treatment with antimicrobial agents (oral or parenteral) for any reason	❑1 Yes	❑0 No
7b.	Urinary tract infection with a urine culture value of >100,000 CFU/ml	❑1 Yes	❑0 No
7c.	Any of the following STD's, such as gonorrhea, chlamydia, mycoplasma, or trichomonas, but not including HIV/AIDS	❑1 Yes	❑0 No
7d.	Prostate biopsy	❑1 Yes	❑0 No
7e.	Experienced symptoms of acute or chronic epididymitis	❑1 Yes	❑0 No
7f.	Diagnosed or treated for symptomatic genital herpes	❑1 Yes	❑0 No

8. Have you had any surgery or procedures on your prostate, scrotum, urinary tract, or lower back in the past six months? ❑1 Yes ❑0 No

If ***Yes***, which of the following have you had done?

8a. Inguinal hernia repair ❑1 Yes ❑0 No

8b. Vasectomy ❑1 Yes ❑0 No

8c. Cystoscopy ❑1 Yes ❑0 No

8d. Urethral Catheterization ❑1 Yes ❑0 No

8e. Lower back surgery ❑1 Yes ❑0 No

9. In the past six months, have you received treatment or therapy for your prostatitis? ❑1 Yes ❑0 No

If ***Yes***, which of the following treatments or therapies have you used?

9a. Antibiotics or antimicrobials (oral or parenteral) ❑1 Yes ❑0 No

9b. Alpha blockers ❑1 Yes ❑0 No

9c. Anti-inflammatories ❑1 Yes ❑0 No

9d. Analgesics (pain killers) ❑1 Yes ❑0 No

9e. Plant extracts ❑1 Yes ❑0 No

9f. Zinc or vitamins ❑1 Yes ❑0 No

9g. Surgery ❑1 Yes ❑0 No

9h. Other ❑1 Yes ❑0 No

Please specify: ______________________________

10. In the past six months, have you started a new clinical trial for your prostatitis? ❑1 Yes ❑0 No

CPCRN	CHRONIC PROSTATITIS COHORT	Inclusion Checklist	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

1. ***Has the patient or parent/legal guardian signed and dated the Informed Consent?*** ❑1 Yes ❑0 No

   If ***Yes***, record the date the form was signed. ___ ___ / ___ ___ / ___ ___ (month / day / year)

2. Is the patient a male? ❑1 Yes ❑0 No

3. Has the patient had symptoms of discomfort or pain in the pelvic region for at least a three month period within the last six months? ❑1 Yes ❑0 No

4. Is the patient eligible for the study? ❑1 Yes ❑0 No
   If any of the shaded boxes are filled in, the patient is NOT eligible.

C P C R N	CHRONIC PROSTATITIS COHORT	Medical History	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Patient Interview Completed)

Prostatitis History

1. Do you know when your first episode of prostatitis was diagnosed? ❑1 Yes ❑0 No

   If ***Yes***, when was it diagnosed? ___ ___ / ___ ___ ___ ___ (month / year)

2. Do you know when your current episode of prostatitis was diagnosed? ❑1 Yes ❑0 No

   If ***Yes***, when was it diagnosed? ___ ___ / ___ ___ ___ ___ (month / year)

3. Have you ever had a prostate biopsy? ❑1 Yes ❑0 No ❑8 Unknown

4. Have you ever had a bladder biopsy? ❑1 Yes ❑0 No ❑8 Unknown

General History

Have you ever had, or do you currently have a history of any of the following?

5. Cardiovascular disease ❑1 Yes ❑0 No ❑8 Unknown

6. Gastrointestinal disease ❑1 Yes ❑0 No ❑8 Unknown

   If ***Yes***,

   6a. Irritable bowel syndrome ❑1 Yes ❑0 No ❑8 Unknown

   6b. Spastic colon ❑1 Yes ❑0 No ❑8 Unknown

   6c. Diverticulitis ❑1 Yes ❑0 No ❑8 Unknown

7. Genitourinary disease ❑1 Yes ❑0 No ❑8 Unknown

If ***Yes***,

7a.	Childhood bladder problems	❑1 Yes	❑0 No	❑8 Unknown
7b.	Urinary stones	❑1 Yes	❑0 No	❑8 Unknown
7c.	Incontinence	❑1 Yes	❑0 No	❑8 Unknown
7d.	Interstitial cystitis	❑1 Yes	❑0 No	❑8 Unknown
7e.	Urinary tract infection	❑1 Yes	❑0 No	❑8 Unknown
7f.	Balanitis	❑1 Yes	❑0 No	❑8 Unknown
7g.	Peyronie's disease	❑1 Yes	❑0 No	❑8 Unknown
7h.	Erectile dysfunction	❑1 Yes	❑0 No	❑8 Unknown

8. Musculoskeletal, rheumatologic, or connective tissue disease ❑1 Yes ❑0 No ❑8 Unknown

If ***Yes***,

8a.	Arthritis	❑1 Yes	❑0 No	❑8 Unknown
8b.	Fibromyalgia	❑1 Yes	❑0 No	❑8 Unknown
8c.	Reiter's syndrome	❑1 Yes	❑0 No	❑8 Unknown

9.	Neurologic disease	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
	If ***Yes***,			
9a.	Migraine headaches	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
9b.	Vertebral disc disease or surgery	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
9c.	Numbness or tingling in limbs	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
10.	Endocrine or metabolic disease	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
	If ***Yes***,			
10a.	Hypothyroid disease	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
10b.	Hyperthyroid disease	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
10c.	Diabetes	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11.	Hematopoietic, lymphatic, or infectious disease	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
	If ***Yes***,			
11a.	Sinusitis	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11b.	Frequent upper respiratory infection	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11c.	Epstein-Barr virus	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11d.	Chronic fatigue syndrome	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11e.	Tuberculosis	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11f.	HIV/AIDS	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown
11g.	Genital herpes	❑$_1$ Yes	❑$_0$ No	❑$_8$ Unknown

Medical History

12.	Dermatologic disease	❑1 Yes	❑0 No	❑8 Unknown
	If ***Yes***,			
12a.	Psoriasis	❑1 Yes	❑0 No	❑8 Unknown
13.	Psychiatric disease	❑1 Yes	❑0 No	❑8 Unknown
	If ***Yes***,			
13a.	Depression	❑1 Yes	❑0 No	❑8 Unknown
13b.	Eating disorder	❑1 Yes	❑0 No	❑8 Unknown
13c.	Anxiety/panic attacks	❑1 Yes	❑0 No	❑8 Unknown
13d.	Suicide attempt	❑1 Yes	❑0 No	❑8 Unknown
14.	Urological surgery	❑1 Yes	❑0 No	❑8 Unknown
	If ***Yes***,			
14a.	Inguinal hernia repair	❑1 Yes	❑0 No	❑8 Unknown
14b.	Scrotal surgery	❑1 Yes	❑0 No	❑8 Unknown
14c.	Vasectomy	❑1 Yes	❑0 No	❑8 Unknown
15.	Allergies	❑1 Yes	❑0 No	❑8 Unknown
	If ***Yes***,			
15a.	Food allergies	❑1 Yes	❑0 No	❑8 Unknown
15b.	Hay fever/seasonal allergies	❑1 Yes	❑0 No	❑8 Unknown
15c.	Asthma	❑1 Yes	❑0 No	❑8 Unknown
15d.	Latex allergy	❑1 Yes	❑0 No	❑8 Unknown

C P C R N	CHRONIC PROSTATITIS COHORT	Prior Treatments and Procedures	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Patient Interview Completed)

Please indicate if you have ever had any of the following procedures for your prostatitis or pelvic pain:

1. Cystoscopy ❑1 Yes ❑0 No ❑8 Unknown

2. Bladder Hydrodistention ❑1 Yes ❑0 No ❑8 Unknown

3. Urethral Dilation ❑1 Yes ❑0 No ❑8 Unknown

4. Other ❑1 Yes ❑0 No ❑8 Unknown

   Please specify, ______________________________

Please indicate if you are presently taking, or have taken in the past, any of the following medications or treatments for your prostatitis or pelvic pain:

		Yes, presently	Yes, in the past	No	Unknown
5.	Antibiotics or antimicrobials (oral or parenteral)	❑1	❑2	❑0	❑8
6.	Anticholinergics or antispasmodics	❑1	❑2	❑0	❑8
7.	Anticonvulsants	❑1	❑2	❑0	❑8
8.	Antidepressants	❑1	❑2	❑0	❑8
9.	Anti-inflammatory medications	❑1	❑2	❑0	❑8
10.	Anti-anxiety medications	❑1	❑2	❑0	❑8
11.	Alpha blockers	❑1	❑2	❑0	❑8

	Prior Treatments and Procedures	Patient ID: 1 ___ ___ ___ ___ Contact Month: ___ 0

		Yes, presently	Yes, in the past	No	Unknown
12.	5-alpha reductase inhibitors	❑ 1	❑ 2	❑ 0	❑ 8
13.	Narcotics	❑ 1	❑ 2	❑ 0	❑ 8
14.	Steroids	❑ 1	❑ 2	❑ 0	❑ 8
15.	Urinary tract analgesics	❑ 1	❑ 2	❑ 0	❑ 8
16.	Allopurinol	❑ 1	❑ 2	❑ 0	❑ 8
17.	Plant extracts or herbs	❑ 1	❑ 2	❑ 0	❑ 8
18.	Zinc	❑ 1	❑ 2	❑ 0	❑ 8
19.	Acupuncture or acupressure	❑ 1	❑ 2	❑ 0	❑ 8
20.	Biofeedback	❑ 1	❑ 2	❑ 0	❑ 8
21.	Electrical stimulation	❑ 1	❑ 2	❑ 0	❑ 8
22.	Prostate massage	❑ 1	❑ 2	❑ 0	❑ 8
23.	Special diet or nutritional supplements	❑ 1	❑ 2	❑ 0	❑ 8
24.	Stress reduction techniques	❑ 1	❑ 2	❑ 0	❑ 8
25.	Other	❑ 1	❑ 2	❑ 0	❑ 8

Please specify, ____

26. Are you currently participating in a clinical trial for your prostatitis? ❑ 1 Yes ❑ 0 No

C P C R N	CHRONIC PROSTATITIS COHORT	Patient Reinstatement	Patient ID: 1 __ __ __ __ Patient Initials: __ __ __ Clinical Center: __ Next Contact Month: __ __ Date: __ __ / __ __ / __ __ (month / day / year) RC ID: __ __ __ __

(Research Coordinator Completed)

This form is to be completed ***ONLY*** if the patient was previously withdrawn from the CPC study and is now being reinstated.

1. Please indicate the ***primary*** reason for reinstatement:
   - ❑1 Previously not interested but returned
   - ❑2 Now willing to follow the protocol
   - ❑3 Previously lost to follow-up but now returned
   - ❑4 Personal constraints have improved
   - ❑5 Medical condition unrelated to prostatitis has improved
   - ❑6 Other
     Please specify: ______________________________________

C P C R N	CHRONIC PROSTATITIS COHORT

Screening Confirmation

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

(RC and PI Completed)

1. Has this patient been fully screened and is now eligible to participate in the CPC study? ❑1 Yes ❑0 No

2. Research Coordinator's signature:

____

Research Coordinator's ID: ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___
month day year

3. Principal Investigator's signature:

____

Principal Investigator's ID: ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___
month day year

C P C R N

CHRONIC PROSTATITIS COHORT

Semen Sample

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

(Research Coordinator Completed)

1. Has the patient remained abstinent for the past 48 hours? ❑1 Yes ❑0 No

2. Was the patient able to provide a semen sample? ❑1 Yes ❑2 No, refused ❑3 No, unable

If ***Yes***, please continue

Semen Microscopy

3. Volume of semen sample ___ ___ . ___ ml

4. White Blood Cell Count (/hpf)
❑1 ≤ 25
❑2 26 - 50
❑3 51-75
❑4 76-100
❑5 >100

If ≤ 25, give actual count ___ ___ /hpf

5. Date seminal plasma sample sent to lab for storage ___ ___ / ___ ___ / ___ ___
month day year

The table below lists the specimens to be identified in each sample, and each specimen's appropriate code. Use these codes when completing the tables for the culture count for each specimen.

Specimen	Specimen Code
Staphylococcus Epidermidis	01
Staphylococcus Aureus	02
Staphylococcus Other	03
Streptococcus Viridans	04
Staphylococcus Hemolyticus	05
Streptococcus Other	06
Enterococcus Fecalis	07
Corynebacterium	08
Escherichia Coli	09
Klebsiella	10
Pseudomonas	11
Proteus	12
Other	13

48 Hour Culture Count

6. Date of 48 hour count __ __ / __ __ / __ __ (month day year)

7. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml

5 Day Culture Count

8. Date of 5 day count __ __ / __ __ / __ __ (month day year)

9. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating what specimens were present, and the culture count measured in CFU/ml:

Specimen Code	< 100,000 OR ≥ 100,000	If < 100,000, please enter actual count
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml
__ __	❑1 <100,000 ❑2 ≥100,000	__ __ __ __ __ CFU/ml

C P C R N

CHRONIC PROSTATITIS COHORT

Serum Sample

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

(Research Coordinator Completed)

1. Was a research serum sample obtained? ❑1 Yes ❑0 No

If ***Yes***, date serum sample sent to lab for storage ___ ___ / ___ ___ / ___ ___
month day year

C P C R N	CHRONIC PROSTATITIS COHORT	Urethral Swab	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

The table below lists the specimens to be identified in each sample, and each specimen's appropriate code. Use these codes when completing the tables for the culture count for each specimen.

Specimen	Specimen Code
Staphylococcus Epidermidis	01
Staphylococcus Aureus	02
Staphylococcus Other	03
Streptococcus Viridans	04
Staphylococcus Hemolyticus	05
Streptococcus Other	06
Enterococcus Fecalis	07
Corynebacterium	08
Escherichia Coli	09
Klebsiella	10
Pseudomonas	11
Proteus	12
Other	13

5 Day Urethral Swab Culture

1. Date of 5 day culture ___ ___ / ___ ___ / ___ ___ (month / day / year)

2. Was there any growth? ❑1 Yes ❑0 No

If ***Yes***, please complete the chart below, indicating which specimens were present

Specimen Code
___ ___
___ ___
___ ___
___ ___
___ ___

C P C R N	CHRONIC PROSTATITIS COHORT	Symptom Index	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Patient Completed)

NIH Chronic Prostatitis Symptom Index

1. Pain or Discomfort
   In the last week, have you experienced any pain or discomfort in the following areas?

   a. Area between rectum and testicles (perineum) ☐$_1$ Yes ☐$_0$ No

   b. Testicles ☐$_1$ Yes ☐$_0$ No

   c. Tip of the penis (not related to urination) ☐$_1$ Yes ☐$_0$ No

   d. Below your waist, in your pubic or bladder area ☐$_1$ Yes ☐$_0$ No

2. In the last week, have you experienced:

   a. Pain or burning during urination? ☐$_1$ Yes ☐$_0$ No

   b. Pain or discomfort during or after sexual climax (ejaculation)? ☐$_1$ Yes ☐$_0$ No

3. How often have you had pain or discomfort in any of these areas over the last week?

   ☐$_0$ Never
   ☐$_1$ Rarely
   ☐$_2$ Sometimes
   ☐$_3$ Often
   ☐$_4$ Usually
   ☐$_5$ Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Urination

How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

- ❑0 Not at all
- ❑1 Less than 1 time in 5
- ❑2 Less than half the time
- ❑3 About half the time
- ❑4 More than half the time
- ❑5 Almost always

7. Impact of Symptoms

How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

8. How much did you think about your symptoms, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

9. Quality of Life

If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ❑0 Delighted
- ❑1 Pleased
- ❑2 Mostly satisfied
- ❑3 Mixed (about equally satisfied and dissatisfied)
- ❑4 Mostly dissatisfied
- ❑5 Unhappy
- ❑6 Terrible

Follow-up of Symptoms

10. ***(If Screening Contact, do not complete question #10.)***
As compared to when you started the study, how would you rate your overall symptoms now?

❑0	❑1	❑2	❑3	❑4	❑5	❑6
Markedly worsened	Moderately worsened	Slightly worsened	No change	Slightly improved	Moderately improved	Markedly improved

Quality of Life SF-12

This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking *one* box. If you are unsure about how to answer, please give the best answer you can.

11. In general, would you say your health is:
    - ❑1 Excellent
    - ❑2 Very good
    - ❑3 Good
    - ❑4 Fair
    - ❑5 Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

12. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
    - ❑1 Yes, limited a lot
    - ❑2 Yes, limited a little
    - ❑3 No, not limited at all

13. Climbing **several** flights of stairs
    - ❑1 Yes, limited a lot
    - ❑2 Yes, limited a little
    - ❑3 No, not limited at all

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

14. **Accomplished less** than you would like
    - ❑1 Yes
    - ❑0 No

15. Were limited in the **kind** of work or other activities
    - ❑1 Yes
    - ❑0 No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

16. **Accomplished less** than you would like
- ❑1 Yes
- ❑0 No

17. Didn't do work or other activities as **carefully** as usual
- ❑1 Yes
- ❑0 No

18. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
- ❑1 Not at all
- ❑2 A little bit
- ❑3 Moderately
- ❑4 Quite a bit
- ❑5 Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the *one* answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

		All of the time	Most of the time	A good bit of the time	A little of the time	None of the time
19.	Have you felt calm and peaceful?	❑1	❑2	❑3	❑4	❑5
20.	Did you have a lot of energy?	❑1	❑2	❑3	❑4	❑5
21.	Have you felt downhearted and blue?	❑1	❑2	❑3	❑4	❑5

22. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
- ❑1 All of the time
- ❑2 Most of the time
- ❑3 A good bit of the time
- ❑4 A little of the time
- ❑5 None of the time

C P C R N	CHRONIC PROSTATITIS COHORT	Uroflow Study	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ 0 Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

1. Total voided volume ___ ___ ___ ml

2. Peak flow ___ ___ . ___ ml/sec

3. Average flow ___ ___ . ___ ml/sec

4. Post-void residual ___ ___ ___ ml

C P C R N	CHRONIC PROSTATITIS COHORT	Voiding Log	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Contact Month: ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month / day / year) RC ID: ___ ___ ___ ___

(Patient Completed)

1. Beginning date and time of log

   ___ ___ / ___ ___ / ___ ___
   month day year

   ___ ___ : ___ ___
   hour minutes

   ❑1 AM
   ❑2 PM

2. Ending date and time of log

   ___ ___ / ___ ___ / ___ ___
   month day year

   ___ ___ : ___ ___
   hour minutes

   ❑1 AM
   ❑2 PM

3. What time did you go to bed?

   ___ ___ : ___ ___
   hour minutes

   ❑1 AM
   ❑2 PM

4. What time did you get up for the day?

   ___ ___ : ___ ___
   hour minutes

   ❑1 AM
   ❑2 PM

5. Which number best describes your AVERAGE pain or discomfort on this day?

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

Voiding Log

Patient ID: 1 ___ ___ ___ ___
Contact Month: ___ ___

Time of void	AM/PM	Amount voided (CC's)	Did you wake to void?
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No

Voiding Log

Patient ID: 1 ___ ___ ___ ___
Contact Month: ___ ___

Time of void	AM/PM	Amount voided (CC's)	Did you wake to void?
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No
___ ___ : ___ ___	❑1 am ❑2 pm		❑1 Yes ❑0 No

C P C R N	CHRONIC PROSTATITIS COHORT	Patient Withdrawal	Patient ID: 1 ___ ___ ___ ___ Patient Initials: ___ ___ ___ Clinical Center: ___ Last Contact Month: ___ ___ Date: ___ ___ / ___ ___ / ___ ___ (month, day, year) RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

This form is to be completed ***ONLY*** if the patient is being withdrawn from future participation in the CPC study.

1. Please indicate the ***primary*** reason for withdrawal:
   - ❑1 No longer interested in participating
   - ❑2 No longer willing to follow the protocol
   - ❑3 Lost to follow-up
   - ❑4 Access to clinic is too difficult
   - ❑5 Unable to make visits during clinic hours
   - ❑6 Unable to continue due to personal constraints
   - ❑7 Unable to continue due to medical condition unrelated to prostatitis
   - ❑8 Other

     Please specify: ____