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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

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Contact Month: 0

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)?

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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

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Contact Month: 0

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

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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