CPCRN 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