

**C
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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

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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?

- | | | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> ₀ | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> 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

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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? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 20. Did you have a lot of energy? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 21. Have you felt downhearted and blue? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
| 22. During the <u>past 4 weeks</u> , how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)? | <input type="checkbox"/> ₁ All of the time
<input type="checkbox"/> ₂ Most of the time
<input type="checkbox"/> ₃ A good bit of the time
<input type="checkbox"/> ₄ A little of the time
<input type="checkbox"/> ₅ None of the time | | | | |