CPCRN CHRONIC PROSTATITIS COHORT

Telephone Contact Checklist

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

(Research Coordinator Completed)

___ ___ - Month Contact

		Completed		If ***No***, Comment
1.	Mail reminder and the Symptom Index (SXIND) prior to call	❑ Yes	❑ No	_____
2.	Receive Symptom Index (SXIND) in the mail	❑ Yes	❑ No	_____
3.	Schedule next contact	❑ Yes	❑ No	_____

(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 No Pain ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 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