(Research Coordinator completed at weeks 1, 2, 3, 6, 14 and 20)

1. How many white capsules are you currently taking every 24 hours?

- ❒0 0 (none)
- ❒1 1
- ❒2 2
- ❒3 3
- ❒4 more than 3

2. How many green capsules are you currently taking every 24 hours?

- ❒0 0 (none)
- ❒1 1
- ❒2 2
- ❒3 more than 2

Part One: ADVERSE EVENTS

3. Since your last scheduled clinic contact, have you had any adverse experiences, abnormal laboratory values, hospitalizations, discontinued medications due to side effects, other complications or pre-existing conditions that worsened?

❒1 Yes ❒0 No

*If **YES**, an Adverse Event Report MUST be completed (except for known ADRs)*

4. Have you either initiated or increased your narcotic drug usage since your last scheduled clinic contact?

❒1 Yes ❒0 No

If ***YES***, *this must be recorded on the patient's Daily Medication Diary.*

Part Two: MEDICATION UPDATE

5. Since your last scheduled clinic contact, have you taken any of the following . . . ?

(See "Exclusionary and Restricted Medications" table and MOP)

a. Tagamet® (cimetidine) ❒1 Yes ❒0 No
(If YES, the patient must be taken off the study.)

b. Intravesical heparin ❒1 Yes ❒0 No
(If YES, the patient must be taken off the study.)

c. Use of more than one gram of aspirin per day for more than three days out of seven? ❒1 Yes ❒0 No
(Bayer®, Anacin®, Excedrin®)

*If **YES,** this must be reflected on the patient's Daily Medication Diary.*

d. Use of more than one maximum allowable dose per day of acetaminophin or aspirin replacement products (NSAIDs) for more than three days out of seven? (Motrin®, Advil®) ❒1 Yes ❒0 No

*If **YES,** this must be reflected on the patient's Daily Medication Diary.*

e. Use of products that contain brompheniramine, diphenhydramine, or chlorpheniramine for more than three days out of seven (except for isolated incidences such as for a "cold")? (Benadryl®, Dimetane®) ❒1 Yes ❒0 No

*If **YES,** this must be reflected on the patient's Daily Medication Diary.*

Part Three: IC TREATMENT UPDATE

6. Since your last scheduled clinic contact, have you started any of the following treatments for your IC? ❒1 Yes ❒0 No

If ***YES***, have you had . . . ?

hydrodistentions	❒1 Yes	❒0 No
bladder instillations	❒1 Yes	❒0 No
biofeedback/mind-body techniques	❒1 Yes	❒0 No
chiropractic treatment	❒1 Yes	❒0 No
accupuncture/accupressure	❒1 Yes	❒0 No
bladder holding/retraining therapy	❒1 Yes	❒0 No
pain clinic	❒1 Yes	❒0 No
peripheral or central electrical stimulation	❒1 Yes	❒0 No
psychotherapy	❒1 Yes	❒0 No
pelvic floor therapies	❒1 Yes	❒0 No
massage therapy	❒1 Yes	❒0 No
homeopathy and/or herbs	❒1 Yes	❒0 No
L-arginine	❒1 Yes	❒0 No
other, specify below:	❒1 Yes	❒0 No

_____

_____

FEMALES ONLY: (Indicate n/a, for males and for females not of childbearing potential.)

7. What was the date of onset of your most recent menstrual period? Date: ___ ___ / ___ ___ / ___ ___
month day year

❒9 Not applicable