ICDB

Interstitial Cystitis Data Base

Patient ID: ___ ___ ___ ___ ___ ___

Date: ___ ___ / ___ ___ / ___ ___
month *day* *year*

Concomitant Medications

This form should list all medications the patient is taking for reasons **other than** urinary symptoms. Medications taken for urinary symptoms should be indicated on the PHYTRT form.

PRIOR medications stopped since last visit or contact:

☐1 **For the first screening visit:** Please check the "None" box and do not complete the table below. Go to the next page.

☐2 **For any other visit type:** Please list any medications stopped since the last visit or contact in the table below. Please check the "None" box if the patient has not stopped any medications since the last visit or contact.

☐0 None

Drug Name	Start Date	Stop Date	Reason
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*	

NEW medications started since last visit or contact:

☐1 **For the first screening visit:** Please list all current concomitant medications in the table below. If the patient is not currently taking any concomitant medications, please check the "None" box.

☐2 **For any other visit type:** Please list any medications started since the last visit or contact in the table below. If the medication was stopped before today's visit, please indicate the stop date. If the patient is still continuing on the medication, please check the "continuing" box. Please check the "None" box if the patient has not started any new medications since the last visit or contact.

☐0 None

Drug Name	Start Date	Stop Date		Reason
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing	