ICDB

Interstitial Cystitis Data Base

Patient ID: ___ ___ ___ ___ ___ ___

Physician ID: ___ ___ ___ ___

Date: ___ ___ / ___ ___ / ___ ___

month day year

Physician's Evaluation and Treatment Plan

1. Type of contact:
   - ☐ 1 Office Visit
   - ☐ 2 Phone Contact *(Please go to question 3.)*

2. How would you rate this patient's overall health?
   - ☐ 5 Excellent
   - ☐ 4 Very good
   - ☐ 3 Good
   - ☐ 2 Fair
   - ☐ 1 Poor

3. Will a cystoscopy be performed on this patient for this study visit?
   - ☐ 1 yes
   - ☐ 0 no

4. Is the patient currently undergoing treatment for her/his urinary symptoms?
   - ☐ 1 yes
   - ☐ 0 no (*Please go to the next page.)*

   a. If **yes**, how effective is this treatment?
      - ☐ 2 Very effective
      - ☐ 1 Somewhat effective
      - ☐ 0 Not at all effective

Please go to the next page.

Current Treatments

*This table should list **all** methods of treatment for the patient's **urinary symptoms.***

PRIOR treatments 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 treatments stopped since the last visit or contact in the table below. Please check the "None" box if the patient has not stopped any treatments since the last visit or contact.

☐0 None

Treatment	Start Date	Stop Date
	___ ___ / ___ ___ *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*
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*
	___ ___ / ___ ___ *month* *year*	___ ___ / ___ ___ *month* *year*

NEW treatments started since last visit or contact:

☐1 **For the first screening visit:** Please list all current treatments in the table below. If the patient is not currently being treated for their urinary symptoms, please check the "None" box.

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

☐0 None

Treatment	Start Date	Stop Date	
	___ ___ / ___ ___ *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
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing
	___ ___ / ___ ___ *month year*	___ ___ / ___ ___ *month year*	☐1 continuing