	Participant ID: __ __ __ __ __ __	**Pin #** __ __ __ __
	Discovery Site: __ __	**Clinical Center** __ __
	CRF Date: __ __/__ __/__ __ __ __	**Visit #:** __ __

Medical History

Research Coordinator completes at Screening Week 0 Contact.

I'm going to ask you some questions . . .

1. Do you know when your chronic pelvic pain symptoms first began? ❑$_1$ Yes ❑$_0$ No
   a. If **YES**, at what age did they first begin? ___ ___ age

2. Have you ever been diagnosed with Painful Bladder Syndrome (PBS) / Interstitial Cystitis (IC)? ❑$_1$ Yes ❑$_0$ No
   a. If **YES**, at what age were you diagnosed? ___ ___ age

3. Have you ever been diagnosed with Chronic Pelvic Pain Syndrome (CPPS) / Chronic Prostatitis (CP)? ❑$_1$ Yes ❑$_0$ No
   a. If **YES**, at what age were you diagnosed? ___ ___ age

I am going to ask you some questions about some medical disorders and conditions. Please tell me if you have ever been diagnosed with any of the following:

Genitourinary Disorders: (Both Men and Women)

3c. Have you had any urinary tract infections (UTIs) in the past two years? ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K

3c1. If Yes, please confirm how many UTIs you have had in the past two years:
❑$_1$ One
❑$_2$ Two
❑$_3$ Three or more

3d. Pelvic floor dysfunction ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

(Women only)

4. Pelvic Inflammatory Disease (PID) ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A
5. Endometriosis ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

5a. Vulvodynia ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

(Men only)

6. Acute prostatitis ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A
7. Epididymitis ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A
8. Peyronie's Disease ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

8a. Orchalgia ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

Medical History

Research Coordinator completes at Screening Week 0 Contact.

Respiratory Tract Disorders/Allergies: (Both Men and Women)

9. Have you been diagnosed with having any respiratory tract disorders and/or allergies? ❑1 Yes ❑0 No ❑88 U/K

If **Yes**, which of the following:

a.	Asthma	❑1 Yes	❑0 No	❑88 U/K
b.	Drug allergies	❑1 Yes	❑0 No	❑88 U/K
c.	Food allergies	❑1 Yes	❑0 No	❑88 U/K
d.	Skin allergies (contact dermatitis)	❑1 Yes	❑0 No	❑88 U/K
e.	Sinusitis	❑1 Yes	❑0 No	❑88 U/K
f.	Hayfever, allergic rhinitis	❑1 Yes	❑0 No	❑88 U/K
g.	Latex allergies	❑1 Yes	❑0 No	❑88 U/K
h.	Other allergies	❑1 Yes	❑0 No	❑88 U/K

Gastrointestinal Disease (Both Men and Women)

10. Have you been diagnosed with having any gastrointestinal diseases? ❑1 Yes ❑0 No ❑88 U/K

If **Yes**, which of the following:

a.	Diverticulitis	❑1 Yes	❑0 No	❑88 U/K
b.	Irritable Bowel Syndrome	❑1 Yes	❑0 No	❑88 U/K
c.	GERD	❑1 Yes	❑0 No	❑88 U/K
d.	Constipation	❑1 Yes	❑0 No	❑88 U/K
e.	Chronic abdominal pain syndrome	❑1 Yes	❑0 No	❑88 U/K

Endocrine or metabolic disease (Both Men and Women)

11. Have you been diagnosed with having any endocrine or metabolic diseases? ❑1 Yes ❑0 No ❑88 U/K

If **Yes**, which of the following:

a.	Diabetes	❑1 Yes	❑0 No	❑88 U/K
b.	Hypothyroid disease	❑1 Yes	❑0 No	❑88 U/K
c.	Hyperthyroid disease	❑1 Yes	❑0 No	❑88 U/K

Hematopoietic, lymphatic, or infectious disease (Both Men and Women)

12. Have you been diagnosed with having any blood, lymphatic, or infectious diseases? ❑1 Yes ❑0 No ❑88 U/K

If **Yes**, which of the following:

Medical History

Research Coordinator completes at Screening Week 0 Contact.

a.	Tuberculosis	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
b.	HIV/AIDS	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
c.	Viral Hepatitis (A,B,C,D,E)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

Psychiatric Disease (Both Men and Women)

13. Have you been diagnosed with having any psychiatric diseases? ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K

If **Yes**, which of the following:

a.	Anxiety disorder (e.g. generalized anxiety disorder, panic disorder, phobia, etc.)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
b.	Depression disorder (e.g. major depression, dysthymia, bipolar disorder)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
c.	Eating disorder (e.g. anorexia nervosa, bulimia)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
d.	Obsessive Compulsive Disorder (OCD)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
e.	Post Traumatic Stress Disorder (PTSD)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

Sexually Transmitted Disease (Both Men and Women)

14. Have you been diagnosed with having any sexually transmitted diseases? ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K

If **Yes**, which of the following:

a.	Gonorrhea	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	
b.	Syphilis	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	
c.	Chlamydia	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	
d.	Genital herpes	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	
e.	Genital warts	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	
f.	Trichomonas	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	
g.	Other sexually transmitted disease	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	

(Men only)

If **Yes**, please respond to the following:

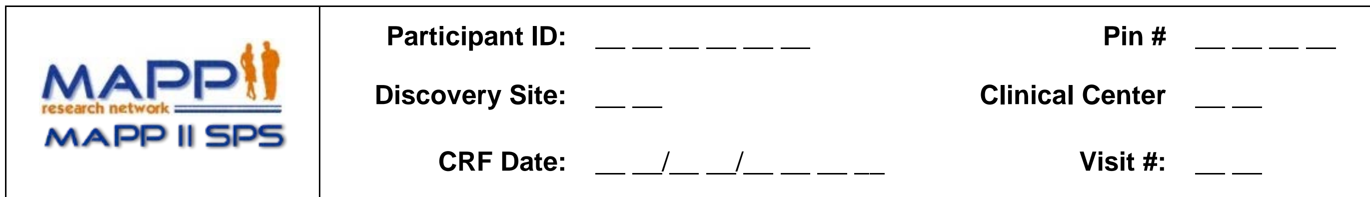
h.	Nongonococcal Urethritis	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K	❑$_{99}$ N/A

Cardiovascular Disease (Both Men and Women)

15. Have you been diagnosed with having any cardiovascular diseases? ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K

If **Yes**, which of the following:

a.	Hypertension	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
b.	High cholesterol	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K


MAPP research network MAPP II SPS	**Participant ID:** __ __ __ __ __ __	**Pin #** __ __ __ __	
	Discovery Site: __ __	**Clinical Center** __ __	
	CRF Date: __ __/__ __/__ __ __ __	**Visit #:** __ __	

Medical History

Research Coordinator completes at Screening Week 0 Contact.

c. Coronary artery disease (heart attack, chest pain)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
d. Stroke	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
e. Arrhythmia	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
f. Palpitations/rapid heart rate	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

Neurologic Disease (Both Men and Women)

16. Have you been diagnosed with having any neurological diseases?	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
If **Yes**, which of the following:			
a. Lumbosacral/Vertebral Disc Disease	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
b. History of seizures	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
c. Migraine headaches	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
d. Peripheral Neuropathy (If ***Yes***, please see **QST MOP**)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
e. Other neurological disease	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

Autoimmune/Other Disorders: (Both Men and Women)

17. Have you been diagnosed with having any autoimmune/ other disorders?	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
If **Yes**, which of the following:			
a. Autoimmune Disorders (ex. Sjogren's Syndrome, Scleroderma)	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
b. Other musculoskeletal, rheumatologic, or connective tissue disease	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
c. Rheumatoid arthritis	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
d. Osteoarthritis	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

QST Screening Criterion (If ***Yes***, please see **QST MOP**)

17c. Do you have any open sores or wounds on either or both of your feet?	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

Now I am going to ask some questions about some surgeries that you may have had.

Non-urological Surgeries (Both Men and Women)

17d. Back surgery	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K
17e. Neck surgery	❑$_1$ Yes	❑$_0$ No	❑$_{88}$ U/K

Medical History

Research Coordinator completes at Screening Week 0 Contact.

Urological/Gynecologic Surgeries:

(Women Only)

18. Have you ever had any urological/gynecologic surgeries? ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

If **Yes**, please respond to the following:

a. Pelvic organ prolapse repair ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

b. Hysterectomy ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

c. Oophorectomy ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

d. Incontinence surgery ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

19. How many children have you given birth to by the following:

a. By vaginal delivery ___ ___ ❑$_{99}$ Not Applicable

b. By Caesarean section ___ ___ ❑$_{99}$ Not Applicable

(Men Only)

Urological Surgeries:

20. Have you ever had any urological surgeries? ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

If **Yes**, please respond to the following:

a. Vasectomy ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

b. Scrotal surgery ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

c. Inguinal hernia repair ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

d. Transurethral Resection of the Prostate (TURP) ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

e. Internal urethrotomy for urethral stricture ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

f. Bladder neck incision ❑$_1$ Yes ❑$_0$ No ❑$_{88}$ U/K ❑$_{99}$ N/A

Research Coordinator/Technician, please review all fields of this form and confirm it is complete by recording your 4-digit ID in the space provided below:

21. Research Coordinator ID ___ ___ ___ ___ (4-digit ID)