



Participant ID: _____	Pin # _____
Discovery Site: _____	Clinical Center _____
CRF Date: ___/___/___	Visit #: ___

Pelvic Therapy History

Research Coordinator completes at Screening Week 0, Baseline Week 4, and Months 6, 18, & 36 in-clinic Follow-up Visits as well as Months 12, 24, & 30 optional clinic visits to document therapies and for MyMED treatment tracking.

Please complete the table below to confirm oral medications and other therapies received for pelvic symptoms.

Oral Medication Therapies (Targeted ATLAS medications)				
Intervention	EVER	RECENT – 6 months	ACTIVE (within month)	
Oral Opioids	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Tricyclic Antidepressants	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Elmiron (Pentosan polysulfate)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Neuropathic Pain Treatments	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Alpha Adrenergic Blockers	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No

Other Therapies				
Intervention	EVER	RECENT – 6 months	ACTIVE (within month)	
Pelvic Physical Therapy (ATLAS therapy)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Procedures with sedation/anesthesia				
Cysto with or without anesthesia (ATLAS therapy)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Botox	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Sacral Neuromodulation	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Bladder Instillations				
Office-based	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Home-based	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Physical Therapy				
Pelvic Focus	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Generalized	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Massage	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Acupuncture	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Counseling/Psychotherapy	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Self-management				
Dietary changes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Bladder Training	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Heat/Cold	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Pelvic floor rehab	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Home Exercise/Yoga	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No
Chiropractic Treatment	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₀ No