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

Symptom and Health Care Utilization Questionnaire

PARTICIPANT COMPLETES THIS FORM AT ALL FOLLOW-UP CONTACTS.

Symptom Severity Scales

Pain, Urgency, Frequency Severity Scales

1. Think about the pain, pressure, and discomfort associated with your bladder/prostate and/or pelvic region. On average, how would you rate these symptoms during the past 2 weeks?

No pain or pressure or discomfort

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

Most severe discomfort I can imagine

2. Urgency is defined as the urge or pressure to urinate. On average, how would you rate the urgency that you have felt during the past 2 weeks?

No urgency

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

Most severe urgency I can imagine

3. Think about your frequency of urination. On average, how would you rate your frequency of urination during the past 2 weeks?

Totally normal

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

Most severe frequency I can imagine

4. On average, during the past 2 weeks, how many times did you urinate in a 24-hour period?

₁ 6 times or less
 ₂ 7-10 times
 ₃ 11-14 times
 ₄ 15 times or more

Urologic or Pelvic Pain Symptom Severity Scales

5. Please rate the overall severity of your **UROLOGIC OR PELVIC PAIN SYMPTOMS** over the past 2 weeks:

No Symptoms

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

Symptoms as bad as they can be

6. Please rate the overall severity of any persistent pain symptoms that were **NOT UROLOGIC OR PELVIC PAIN SYMPTOMS** (e.g. back pain, headache, etc) over the past 2 weeks:

No Symptoms

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

Symptoms as bad as they can be



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Symptom and Health Care Utilization Questionnaire

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7. Please rate your **MOOD** over the past 2 weeks:

Extremely Good Mood											Extremely Bad Mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
0	1	2	3	4	5	6	7	8	9	10	

8. What was your single most bothersome symptom over the past two weeks?
(Please select only **ONE** answer.)


Pain, pressure, discomfort in:

- ₁ Pain, pressure, discomfort in your pubic or bladder area
- ₂ Pain, pressure, discomfort in the area between: your rectum and testicles (perineum) **[MALES only], -OR- the vaginal area [FEMALES only].**
- ₃ Pain/ discomfort during or after sexual activity
- ₄ Strong need to urinate with little or no warning
- ₅ Frequent urination during the day
- ₆ Frequent urination at night
- ₇ Sense of not emptying your bladder completely
- ₈ Other: _____

We would like to know if your urologic or pelvic pain symptoms have caused you to seek medical care in the past 2 weeks:

9. Have your urologic or pelvic pain symptoms been severe enough that they caused you to do any of the following in the past 2 weeks:

- a. Contacted a healthcare provider (physician, nurse, physical therapist or other provider) by telephone or e-mail? ₁ Yes ₀ No
- b. Seen a healthcare provider in his/her office? ₁ Yes ₀ No
- c. Made a trip to an emergency room or urgent care center? ₁ Yes ₀ No
- d. Had a medication changed (new medication or different dose)? ₁ Yes ₀ No
- e. Undergone a medical procedure? ₁ Yes ₀ No

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Symptom and Health Care Utilization Questionnaire

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10. Do you know when you had your most recent (or last) menstrual period? ₁ Yes
 (Question #10 is for Female Participants **ONLY**.
 Please record **"99/Not Applicable"** for Female Participants
 who are **NOT** of child-bearing potential.) ₀ No
₉₉ Not Applicable
- a. If **Yes**, please give the date of most recent (or last) menstrual period: Date: ____/____/____
MM DD YYYY
- b. If **No**, you have not had a menstrual period because of:
₁ Contraceptive ₂ Prior Hysterectomy ₃ Postmenopausal

Flare Status Question

11. Are you currently experiencing a flare of your urologic or pelvic pain symptoms? By this we mean, are you currently experiencing symptoms that are much worse than usual? ₁ Yes ₀ No