FORM NUMBER = (FORM)
FORM VERSION = (VERS)

NIH - BPH TRIAL

PROSTATITIS QUESTIONNAIRE

This form is to be completed at Screening Visit 2, Major Follow-up Visits and End of Study. The patient should complete page 2.

Part I / IDENTIFICATION

A. Patient Identification

1. Clinic number **(CLINIC)** ☐☐

2. Patient Identification Number (Complete a **OR** b)

   a. If before randomization, Screening number **(SCREEN)** S☐☐☐☐

   b. If after randomization, Patient number **(PATID)** ☐☐☐☐☐ (clinic / patient)

3. Patient's initials **(INITS)** ☐☐☐☐ (first / last)

4. Patient's date of birth **(DOB)** ☐☐/☐☐/☐☐ (month / day / year)

B. Visit Information

1. Date of visit **(PVSTDT)** ☐☐/☐☐/☐☐ (month / day / year)

2. Type of visit **(PVITYP)**
   - [1] Screening
   - [2] Major Follow-up
   - [3] End of Study

3. If Major Follow-up or End-of Study Visit, week of visit **(PVIWK)** ☐☐☐

Part II / PROSTATITIS QUESTIONNAIRE

The patient should complete the questionnaire on the following page.

Initials of person completing form **(FORMIN)** ☐☐☐☐ (first / last) Form entered in computer? ☐

Patient number | | | | | |

Date of visit | | month | | day | | year |

Please put an "X" in the box for the answer that best describes the symptoms you are currently experiencing.

	No Pain	Occurs Occasionally (Not Every Day)	Usually But Does Not Stop Activity	Incapacitating
1. Pain, aching or pressure behind the scrotum, inside the rectum or in the inner thighs **(PSCROT)**	0	1	2	3
2. Pain, aching or pressure in the testicles **(PTEST)**	0	1	2	3
3. Pain, aching or pressure in the lower abdomen or groin area **(PABDGR)**	0	1	2	3
4. Pain, aching or pressure in the tip of the penis or during urination **(PPEN)**	0	1	2	3

Please initial here _____