

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)

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2. Patient Identification Number (Complete a OR b)

a. If before randomization, Screening number (SCREEN)

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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)

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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?

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Patient number

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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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Pain, aching or pressure in the testicles (PTEST)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain, aching or pressure in the lower abdomen or groin area (PABDGR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pain, aching or pressure in the tip of the penis or during urination (PPEN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please initial here _____