Patient Information Form
IC Study

Name: _____

Address: _____

Phone number: _____Cell number: _____

Email address: _____

Date of birth: _____

How you were diagnosed with IC:_____

_____

Medicines used for IC: _____

_____

Treatments used for IC: _____

_____

Regular Medicines: _____

Allergies: _____

Surgeries: _____

Primary Physician's name and address: _____

_____

Urologist's name and address: _____

_____

Pharmacy and phone number: _____

Would you consider being in a research project? Questions or problems you have being in a research project: _____

_____