Supplementary information: Standardised symptom sheet

Patient ID……
Instillation No……
Date……

IRRITATIVE BLADDER SYMPTOM SCORE SHEET

Think about how much you may have experienced the following symptoms over the last week. Using a rating between 0 (no symptoms) to 10 (severe symptoms),

Please indicate your score (between 0-10) in the columns provided.

0 ——— 5 ——— 10
No symptoms Moderate symptoms Severe symptoms

B.C.G. Treatment Day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Bladder pain or discomfort							
Getting up at night to go to the toilet.							
Going to the toilet frequently during the day.							
Difficulty postponing urination due to urgency.							
Burning sensation in the bladder.							
Burning and/or discomfort when passing urine							
Burning and/or discomfort after passing urine							
Blood or blood clots in the urine							
Genital itch/pain							
Burning sensation or pain in the penis							

Patient ID……
Instillation No……
Date……

SYSTEMIC RESPONSE SYMPTOM SCORE SHEET

Please tick a box in the appropriate column if you have experienced any of the following:

B.C.G. Treatment Day	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Fever/Chills							
Muscular aches							
Malaise/Excessive tiredness							
Nausea/loss of appetite							
Joint pain or swelling							
Persistent cough							
Skin rash							
Abdominal pain							
Sore/red/itchy eyes							