Pelvic Pain Patient Questionnaire

Name: _____Age: _____ DOB:_____

Referred by:_____

How long have you had pelvic pain? _____years _____months _____weeks

Can you think of any event associated with its onset?

_____

Where is your pain located? Please circle all that apply:

Abdomen: Right upper Left upper Right lower Left lower	**Rectum**	**Hip:** Right Left
Back: Upper Lower	**Thigh:** Right Left	**Neck**
Vulvar area	**Buttock:** Right Left	**Vagina**

On a scale from 0 (no pain at all) to 10 (the worst pain ever), how severe is your pain? Please circle:

- At its worst? 0 1 2 3 4 5 6 7 8 9 10
- At its best? 0 1 2 3 4 5 6 7 8 9 10
- On average? 0 1 2 3 4 5 6 7 8 9 10

Please circle all answers that apply in regards to the quality of your pain:

Throbbing	Shooting	Hot-burning	Constant
Cramping	Stabbing	Sickening	Waxing/waning
Aching	Sharp	Exhausting	Paralyzing
Heavy/pressure	Splitting	Electrical	Other:

What makes your pain worse?

Sexual intercourse	Exercise	Standing	Stress
Full bladder	Urination	Sitting	Periods
Full meal	Bowel movement	Weather	Position change
Walking	Coughing/sneezing	Contact with clothing	Other

What makes your pain better?

Relaxation	Heating pad	Pain medications	Stretching
Lying down	Meditation	Laxatives/enema	TENS unit
Massage	Music	Bowel movement	Nothing
Hot bath	Ice/cold pad	Emptying bladder	Other:

Menstrual History:

- Are you still having periods? Yes No
- My periods are: (please circle all answers that apply)
  - Regular Irregular
  - Light Moderate Heavy I bleed through protection
  - Painful Not painful Sometimes painful

In the last month, have you had the following, and if so, how severe on the scale of 0-10:

1. Pain with ovulation (mid cycle): Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
2. Pain before period: Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
3. Pain with period (cramps): Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
4. Pain with intercourse (deep): Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
5. Pain with intercourse (with insertion): Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
6. Pain after intercourse: Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
7. Burning in vagina/vulva during or after intercourse: Yes No
   - 0 1 2 3 4 5 6 7 8 9 10
8. Pain with sitting or standing: Yes No
   - 0 1 2 3 4 5 6 7 8 9 10

Urinary Symptoms:

Do you have any pain or burning with urination? Yes No

Do you have a history of bladder infections? Yes No

- Recurring bladder infections? Yes No
- Were you given antibiotics in the past? Yes No

Do you have urinary frequency? Yes No

- How many times a day do you go to the bathroom? _____

Do you have urgency? Yes No

Do you have the urge to urinate during sexual intercourse?

How many times do you wake up to go to the bathroom at night? _____

Do you have pain with full bladder? Yes No

- Does your pain get better when you empty your bladder? Yes No

GI symptoms:

In the last 3 months, have you had any of the following (please circle all answers that apply)**:**

- Bloating
- Alternating diarrhea and constipation
- Alternating hard and soft/liquid stool
- Difficulty passing bowel movements
- Passage of mucus
- Abdominal pain relieved with bowel movement

Previous treatments for current problem:

1. Medications: _____
2. Surgeries (please list): _____
_____
3. Psychiatry/psychology evaluation: _____
4. Counseling: _____
5. Physical therapy: _____
6. Acupuncture: _____
7. Trigger point injections: _____
8. Other: _____

Health Habits:

How often do you exercise? ____rarely ____1-2 times weekly ____3-5 times weekly ____daily

What is your caffeine intake (number of cups per day, include coffee, tea, soft drinks) _____

Are you following any specific diet? If yes, what kind?

_____

Have you ever received treatment for substance abuse? Yes No

What is your use of recreational drugs? ____Never used ____Used in the past but not now ____Presently using

Heroin Amphetamines Marijuana Barbiturates Cocaine Other_____

Have you ever been abused sexually, emotionally, verbally or physically? Yes No

Are you safe now? Yes No