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Pelvic Pain Questionnaire

Name:_____ DOB:_____ Age: _____ Today's Date: _____

1. Please describe your pain problem: _____

   _____

   _____

2. What do you think is causing your pain?_____

3. Is there an event that you associate with the onset of your pain *(Please circle)*?
   First Period / Pregnancy / Injury / Surgery / Infection / Other: _____

4. How long have you been having pain? _____ years _____ months _____ weeks

5. Is your pain staying the same or getting worse? _____

6. Is your pain constant or does it come and go? _____

7. Is your pain present when you wake up? ☐ No ☐ Yes

8. Does your pain get worse throughout the day? ☐ No ☐ Yes

9. Where is your pain *(circle all that apply, star the worst location)*?

   a. Back: Upper / Lower
   b. Buttock: Right / Left
   c. Hip: Right / Left
   d. Thigh: Right / Left
   e. Abdomen: Right Upper / Left Upper
      Right Lower / Left Lower
   f. Pelvis: Right / middle / Left
   g. Vagina
   h. Vulva
   i. Rectum
   j. Bladder

10. How would you describe your pain *(circle all that apply, star the best answer)*?

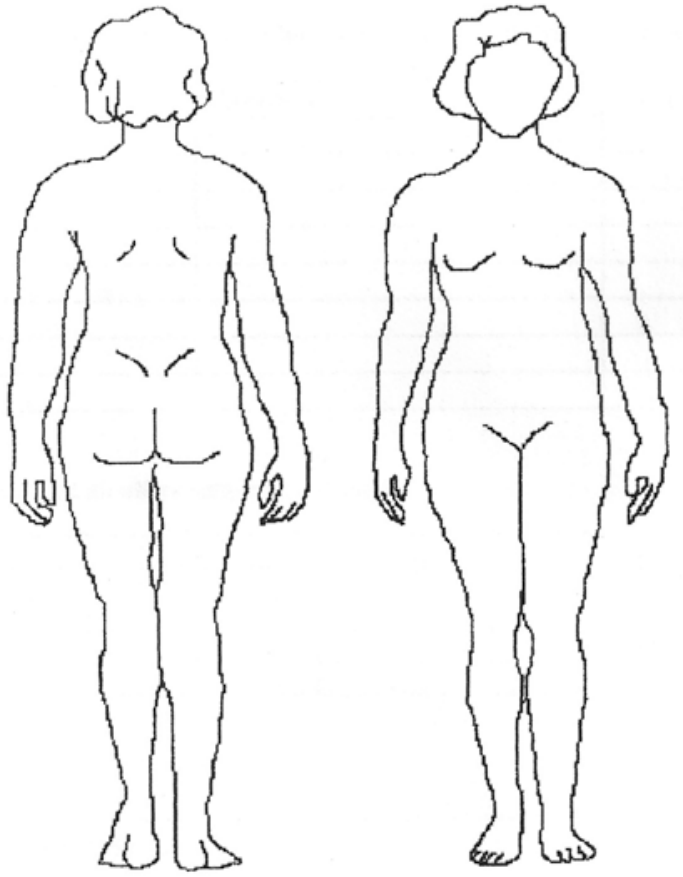
Throbbing	Cramping	Stabbing	Sharp	Hot/burning
Aching	Heavy/pressure	Shooting	Electrical	Constant
Comes & goes	Waxing/waning	Splitting	Sickening	Other: _____

11. On a scale of 0 (no pain at all) to 10 (worst pain imaginable), what is your pain level *(circle)*?

    a. At its worst? 0 1 2 3 4 5 6 7 8 9 10
    b. At its best? 0 1 2 3 4 5 6 7 8 9 10
    c. On average? 0 1 2 3 4 5 6 7 8 9 10

Pain Maps

Please shade areas of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)



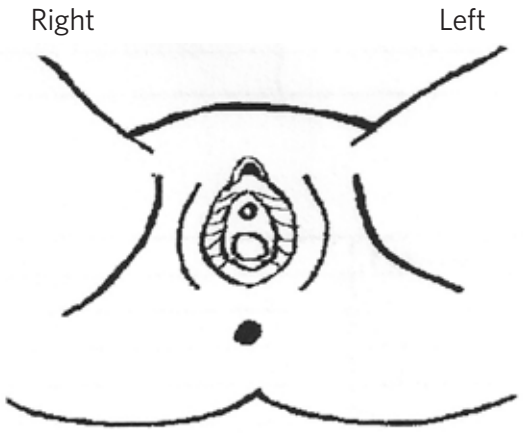
Vulvar / Perineal Pain

(pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10 = most severe pain imaginable)

Is your pain relieved by sitting on a commode seat?

☐ Yes ☐ No



12. What makes your pain worse *(circle all that apply, star the best answer)*?

Periods	Full bladder	Urination	Bowel Movement
Standing	Sitting	Walking	Exercise
Stress	Position change	Full meal	Weather
Coughing/sneezing	Clothing	Other: _____	

13. What makes your pain worse *(circle all that apply, star the best answer)*?

Relaxation	Lying down	Massage	Stretching
Physical Therapy	Hot bath	Heating pad	Ice/cold pack
Emptying bladder	Bowel movement	Laxatives	Pain medications
Birth control pills	Lupron	Other: _____	

14. Menstrual Pain: If you have had any of the following pain within the past month, please rate it on a scale from 0-10 *(circle)*?

a. Pain with ovulation (mid cycle):	0	1	2	3	4	5	6	7	8	9	10
b. Pain starting just before your period:	0	1	2	3	4	5	6	7	8	9	10
c. Pain (not cramps) during your period:	0	1	2	3	4	5	6	7	8	9	10
d. Menstrual cramps:	0	1	2	3	4	5	6	7	8	9	10
e. Pain between period (not ovulatory):	0	1	2	3	4	5	6	7	8	9	10

15. Menstrual Pain:
    a. Do you have deep pain with intercourse? ☐ No ☐ Yes
    b. Rate this pain on a scale from 0-10: 0 1 2 3 4 5 6 7 8 9 10
    c. Is the pain triggered by certain sexual positions? ☐ No ☐ Yes
    d. Is the pain relieved by changing positions? ☐ No ☐ Yes
    e. How long after intercourse does the pain linger? _____ Hours _____ Days
    f. Do you avoid intercourse because of pain? ☐ No ☐ Yes
    g. How often do you have to stop intercourse due to pain *(circle)*?
        - Rarely / Sometimes / Often / Always / "I tough it out"

16. Vaginal and Vulvar Pain:
    a. Do you have pain to touch or entry into the vagina? ☐ No ☐ Yes
    b. Do you have frequent/recurrent yeast infections? ☐ No ☐ Yes
    c. Do you "clamp down" during intercourse? ☐ No ☐ Yes
    d. Do you frequently have itching or burning? ☐ No ☐ Yes
    e. Do you have itching/burning after intercourse? ☐ No ☐ Yes
    f. Do you have vulvar pain that is worse when sitting? ☐ No ☐ Yes

17. Bladder Pain:
    a. Do you have an unpleasant sensation with full bladder? ☐ No ☐ Yes
        - Is this relieved by urination? ☐ No ☐ Yes
        - Is this worse during your periods? ☐ No ☐ Yes
        - Is this worse with stress? ☐ No ☐ Yes
    b. Do you feel the urge to urinate during intercourse? ☐ No ☐ Yes
    c. How many times do you urinate while awake? 3-6 / 7-10 / 11-14 / 15-19 / 20+
    d. How many times do you wake at night to urinate? 0 / 1 / 2 / 3 / 4+
    e. Do you have to hurry to empty your bladder? ☐ No ☐ Yes
        - Do you ever lose urine with this urge? ☐ No ☐ Yes
    f. Do you have pain with urination? ☐ No ☐ Yes
    g. Have you recently passed blood in your urine? ☐ No ☐ Yes
    h. Do you have difficulty passing urine? ☐ No ☐ Yes

18. Gastrointestinal Pain:
    a. Do you have recurrent abdominal pain that is:
        - Relieved by bowel movements? ☐ No ☐ Yes
        - Associated with change in stool appearance? ☐ No ☐ Yes
        - Associated with change in frequency of BM? ☐ No ☐ Yes
        - Is this pain worse during your periods? ☐ No ☐ Yes
    b. Do you frequently have constipation? ☐ No ☐ Yes
    c. Do you frequently have diarrhea? ☐ No ☐ Yes
    d. Have you recently had blood in your stool? ☐ No ☐ Yes

19. Previous medical treatments *(check all that apply)*:
    a. ☐ Anti-inflammatories
    b. ☐ Narcotics
    c. ☐ Monthly birth control pill
    d. ☐ 3 month cycle birth control pill
    f. ☐ Depo Provera
    g. ☐ Mirena IUD
    h. ☐ Lupron
    i. ☐ Physical Therapy

20. Previous surgical treatments:
    a. Have you ever had surgery for pelvic pain? ☐ No ☐ Yes
        - How many surgeries? _____
        - How long ago was your last surgery? _____
    b. Was endometriosis found? ☐ No ☐ Yes
        - Involving the bowel or bladder? ☐ No ☐ Yes
    c. Were adhesions (scar tissue) found? ☐ No ☐ Yes

21. Other types of pain *(circle all that apply)*:
    Chronic Headache/ Migraine TMJ (Jaw) Pain Chronic Back pain
    Fibromyalgia Interstitial Cystitis (Bladder Pain Syndrome)
    Irritable Bowel Syndrome (IBS) Chronic Fatigue Syndrome
    Autoimmune Disease (Lupus, Rheumatoid Arthritis, Sjogren's Disease, etc.)

22. Fertility:
    a. Do you desire to become pregnant? ☐ No ☐ Yes
    b. Are you actively trying to become pregnant? ☐ No ☐ Yes
        - How long have you been trying? _____
    c. Have you ever used fertility treatments? ☐ No ☐ Yes
        - If so, what treatments? _____

23. Mental Health:
    a. Have you ever been diagnosed with Depression? ☐ No ☐ Yes
        - Treatment? _____
    b. Over the past two weeks, have you felt:
        - Down, depressed, or hopeless? ☐ No ☐ Yes
        - Little interest or pleasure in doing things? ☐ No ☐ Yes
    c. Have you ever been abused sexually, physically, or verbally? ☐ No ☐ Yes
        - Are you safe now? ☐ No ☐ Yes