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
   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
- Standing Sitting Walking
- Stress Position change Full meal
- 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):
   b. Pain starting just before your period:
   c. Pain (not cramps) during your period:
   d. Menstrual cramps:
   e. Pain between period (not ovulatory):
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
   e. ☐ Depo Provera
   f. ☐ Mirena IUD
   g. ☐ Lupron
   h. ☐ Physical Therapy

20. Previous surgical treatments:
   a. Have you ever had surgery for pelvic pain?
      - How many surgeries? _______________________
      - How long ago was your last surgery? _______________________
   b. Was endometriosis found?
      - 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?
      - How long have you been trying? _______________________
   c. Have you ever used fertility treatments?
      - If so, what treatments? ____________________________________________

23. Mental Health:
   a. Have you ever been diagnosed with Depression?
      - 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?
      - Are you safe now? ☐ No ☐ Yes