Women's Wellness Center
Pelvic Pain Consultation Patient Questionnaire

Name ____ Date of Birth _______________ Date ________________

Please answer these questions as thoughtfully and completely as you are able. Take your time, and read the questions carefully. It may take 20-40 minutes to complete our pelvic pain questionnaire, and it's a good idea to *read all 4 pages entirely before beginning to write your answers*. We sincerely want to help you, and this detailed information will allow us to do a better job.

Information About Your Pain

1. Describe your pelvic pain, including specific location(s) of pain.

____

____

____

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

3. Is there an event that you associate with the first onset of your pain? ___No ___Yes If yes, what? _______________________

4. How long have you had this pain? ________________________ 5. Is the pain constant or intermittent? (Circle one)

6. If intermittent, when do you have pain? (random, cyclic, time of day)?____

7. Is the pain related to your menstrual cycle? ___ before period ___ during period ___after period ___ not related to cycle

8. How long does the pain last? ____

9. What helps your pain? ____

10. What makes your pain worse (activity, sitting, standing, etc)? ____

11. Have you had pain or problems with pelvic exams? ___ No ___ Yes Explain __________________________________

12. Have you had pain or problems with use of tampons? ___ No ___ Yes Explain ________________________________

13. Do you have pain with intercourse? ___No ___Yes If yes, give more information about pain:

___ External (skin) ___At vaginal opening ___Vaginal walls ___Deep in vagina (with thrusting)

___ Internal Abdomen/Pelvis ___Pain worse with orgasm ___ pain relieved with orgasm

Does the pain continue after intercourse? ___No ___Yes If yes, how long? ___________________________________

Do you have vaginal dryness? ___No ___Yes Do you use a lubricant? ____

Does pain cause intercourse to be impossible? ___No ___Yes ___Sometimes

14. How would you describe the pain? (Circle all that apply):

Throbbing Shooting Stabbing Sharp Dull Cramping Gnawing Burning Aching

Pulling Heavy Tender to touch Tearing Sickening Tiring Fearful Punishing/Cruel

15. Do you have pain every day? ___yes ___no If no, how often? ___1 day/wk or less ___2-3 days/wk ___4-5 days/wk

16. Describe severity of the pain by writing a numeral 0-10 next to each time of day:

Morning____ Daytime____ Evening____ Through the Night ____

Physician Notes ____

____

____

____

____

____

____

____

____

Previous and Current Medications for Pelvic Pain

17. List all previous medications for this pelvic pain, both prescription and over-the-counter, including natural or herbal remedies. Include dates, prescriber (if applicable), and whether the treatment was helpful or not. Use page 4 if need more space.

Medication / Dose	Approx. Dates	Provider (if any)	Did it Help?	Currently Taking?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Other Current Medications.

18. List all **other** medications you are presently taking, with date initiated, prescriber, and reason. Use page 4 if need more space.

Medication / Dose	Date Started	Prescriber (if any)	Reason

Previous Treatments for Pelvic Pain

19. List all previous treatments you have tried for this pelvic pain , (diet or habit/behavioral changes, surgeries, other therapies), both healthcare provider recommended and self-directed. Use page 4 if need more space.

Treatment	Approx. Dates	Provider (if any)	Did it Help?

Other Past Surgeries (if not listed above)

20. List all surgeries you have had, if not already listed above. Use page 4 if need more space.

Surgery	Date	Physician	Reason

Physician Notes

____

____

Medical History

21. List medical problems / diagnoses ____

____

____

22. Have you been treated for depression? ___No ___Yes -- Treatments: ___Medication ___Hospitalization ___Counseling

23. List major accidents, (motor vehicle, falls, back injury, etc): ________________________________

Menstrual History

24. Do you have menstrual periods? ___ Yes ___ No If no periods, when was your last (year or month) ____________

25. If you have periods:

 Are your periods regular? ___ Yes ___No If no, give details ________________________________

 Describe your menstrual flow: ___light ___moderate ___heavy ___very heavy with clots ___crampy

Obstetric and Gynecologic History

26. Birth Control: None Partner Vasectomy Pill IUD Tubal Condom Other ______________________

27. If you have had pregnancies:

 a. How many vaginal births?____ How many C-sections?_____ Forceps deliveries?____ Miscarriages?____ Abortions?_____

 b. Have you had a 3rd or 4th degree episiotomy or vaginal laceration? ___No ___Yes

 c. Have you had a difficult childbirth experience? (Explain) ________________________________

____

28. Have you been diagnosed with: ___Infertility ___Endometriosis ___Pelvic inflammatory disease ___ Ectopic pregnancy

29. Have you had recurrent vaginal infections or vaginal discharge? ___No ___Yes If yes, describe problems and treatments:

____

____

____

Social History

30. Your Employer ______________________ 29. Your Occupation ______________________

31. You are (circle all that apply): Single Married Widowed Separated Divorced Remarried In a Committed Relationship

32. Who do you live with? ________________________________

33. How does your partner deal with your pain? (Circle all that apply)

Not Applicable	Takes care of me	Understanding, patient
Doesn't notice	Withdraws	Feels helpless
Gets angry	Other __________	

Habits

34. Exercise Frequency: ___Rare / Never ___1-2 times / wk ___3-5 times / wk ___Daily ___I can't exercise because of pain

35. Caffeine intake per day (number of cups tea/coffee, sodas, etc): ___None ___ 1-3/day ___4-6/day ___ >6/day

36. Alcohol intake (number drinks per day – or per wk / month if less than daily): ___None ___ / day ___ / week ___ / month

37. Do you smoke cigarettes? ___No ___Yes. If yes how many per day? __________ For how many years? __________

38. What is your recreational drug use? ___Never ___In past, not now ___Presently using ___No answer

 Heroin Amphetamines Marijuana Barbiturates Cocaine Other ______________

Sexual and Physical Abuse History

39. Have you been the victim of chronic emotional abuse? This can include being often humiliated or insulted. ___No ___Yes

40. As a child or adult, have you experienced physical abuse / physical assault? ___No ___Yes

41. As a child or adult, have you experienced sexual abuse? ___No ___Yes

42. If you answered yes to any question in this box, please explain, if you feel comfortable doing so. This information may help us do a better job of caring for you. ________________________________

____

____

Bladder Symptoms

43. As a child, did you have frequent bladder infections? ___No ___Yes

44. As an adult have you had frequent bladder infections? ___No ___Yes

a. If yes, what antibiotics have been effective for you? ______________________________

b. Have you ever taken a prolonged course, or daily use of antibiotics for prevention of bladder infection? ___ No ___Yes

45. Do you often feel like you have a bladder infection, yet the urine test reveals you don't? ___No ___Yes

46. Do you ever have blood in the urine (not from menses)? ___No ___Yes

47. Do you feel as if you sometimes cannot completely empty your bladder? ___No ___Yes

48. Do you sometimes have to void again within minutes of voiding? ___No ___Yes

49. How often do you urinate during the daytime? ____________________ How often at night? ____________________

50. Do you leak urine when you feel the urge to go, and can't make it to the toilet in time? ___No ___Yes

51. Do you leak urine when you cough, sneeze, laugh, or exercise? ___No ___Yes

52. Do you have bladder pain? ___No ___Yes Pain during urination? ___No ___Yes -- Where does it hurt? ______________

Bowel Symptoms

53. Do you have any problems with bowel emptying? ___No ___Yes If yes, describe ______________________________

54. Are bowel movements painful? ___No ___Yes Blood in the stool? ___No ___Yes Hemorrhoids? ___No ___Yes

55. Is your pelvic pain relieved after bowel movements? ___No ___Yes

56. Do you have urgency of bowel movements (have to get to the toilet quickly)? ___No ___Yes

57. Do you have fecal incontinence (leaking stool)? ___No ___Yes If yes, how often? ____________________________

58. Do you have problems with constipation? ___No ___Yes Diarrhea? ___No ___Yes

Additional Information

Use this section if you need more space for answering questions (please indicate question number if applicable).

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Physician Notes

____
____
____
____
____
____