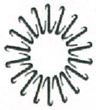


Women's Medicine Collaborative
Lifespan. Delivering health with care.

Pelvic Pain Program
Sarah Fox, MD, FACOG
146 West River St, Providence, RI 02904
3rd Floor, Suite 11D (401) 793-7917

Patient Label

Physician: Dr. Sarah Fox ________ Date: ____________
Patient's Name: ______________________ Date of Birth: ____________
Phone: Home ____________ Cell ______________ Work ______________
Referring Provider's Name: ______________ Address: ______________________

Information About Your Pain

Please describe your pain problem (use a separate sheet of paper if needed): ______________________
____
____
____
____
____

What do you think is causing your pain? ______________________
Is there an event that you associate with the onset of your pain? ☐ No ☐ Yes If so, what? ____________
How long have you had this pain? _______ years ________ months

For each of the symptoms listed below, please circle your level of pain ***over the last month*** *using a 10-point scale.*

0 = no pain | 3-4 = able to do activity and distract yourself from the pain | 4-5 = pain interrupts activities
6-7 = unable to focus | 8 = you are thinking about going to the hospital | 9-10 = to the hospital

Pain at ovulation (mid-cycle)	0	1	2	3	4	5	6	7	8	9	10
Pain just before period	0	1	2	3	4	5	6	7	8	9	10
Pain (not cramps) before period	0	1	2	3	4	5	6	7	8	9	10
Level of cramps with period	0	1	2	3	4	5	6	7	8	9	10
Pain after period is over	0	1	2	3	4	5	6	7	8	9	10
Deep pain with intercourse	0	1	2	3	4	5	6	7	8	9	10
Burning vaginal pain after intercourse	0	1	2	3	4	5	6	7	8	9	10
Pelvic pain lasting hours or days after intercourse	0	1	2	3	4	5	6	7	8	9	10
Pain when bladder is full	0	1	2	3	4	5	6	7	8	9	10
Pain with urination	0	1	2	3	4	5	6	7	8	9	10
Pain in groin when lifting	0	1	2	3	4	5	6	7	8	9	10
Muscle/Joint pain	0	1	2	3	4	5	6	7	8	9	10
Backache	0	1	2	3	4	5	6	7	8	9	10
Pain with sitting	0	1	2	3	4	5	6	7	8	9	10
Migraine headache	0	1	2	3	4	5	6	7	8	9	10

Pain scores over **the last week** (0-10): Average ______ Maximum ________ Minimum _______

Information About Your Pain Management

What types of treatments/providers have you tried in the past for your pain? Please check all that apply.

☐ Acupuncture
☐ Anesthesiologist
☐ Anti-seizure medications
☐ Antidepressants
☐ Biofeedback
☐ Botox injection
☐ Contraceptive pills/patch/ring
☐ Danazol (Danocrine)
☐ Depo-Provera
☐ Gastroenterologist
☐ Gynecologist
☐ Family Practitioner
☐ Herbal Medicine
☐ Homeopathic medicine
☐ Lupron, Synarel, Zoladex
☐ Massage
☐ Meditation
☐ Narcotics
☐ Naturopathic medication
☐ Nerve blocks
☐ Neurosurgeon
☐ Nonprescription medication
☐ Nutrition/Diet
☐ Physical Therapy
☐ Psychotherapy
☐ Psychiatrist
☐ Rheumatologist
☐ Skin magnets
☐ Surgery
☐ TENS unit
☐ Trigger point injections
☐ Urologist
☐ Other: ______________

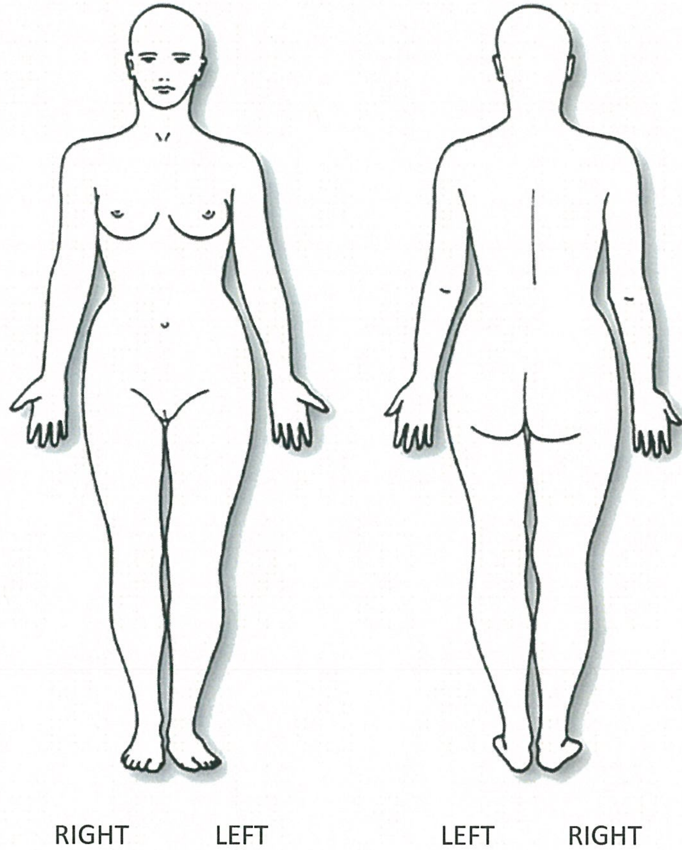
Patient Label

Of all the problems or stresses in your life, how does your pain compare in importance?

☐ The most important problem ☐ Just one of many problems

Pain Maps

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



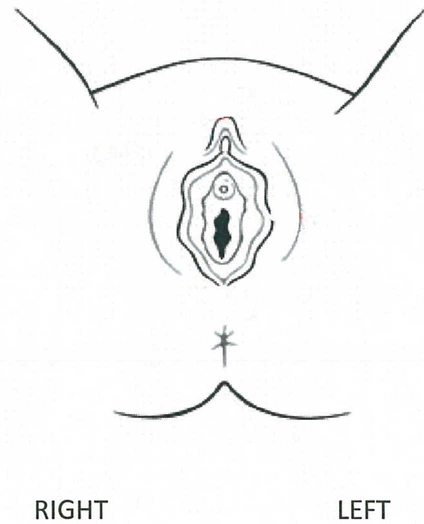
RIGHT LEFT LEFT RIGHT

Vulvar/Perineal Pain

(pain outside and around the vagina and anus)

If you have vulvar pain, shade the painful area(s) and write a number from 1 to 10 at the painful site(s).

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No



RIGHT LEFT

*What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?*

Physician / Provider	***Specialty***	***City, State, Phone #***

Social History

Are you (check all that apply): ☐ Married ☐ Single ☐ Widowed ☐ Remarried ☐ Separated ☐ Divorced ☐ Committed Relationship

Who do you live with? ____________________

Education: ☐ Less than 12 years ☐ High School graduate ☐ College degree ☐ Postgraduate degree

What type of work are you trained for? ____________________

What type of work are you doing? ____________________

Family History

Has anyone in your family had:

☐ Fibromyalgia ☐ Chronic pelvic pain ☐ Irritable bowel syndrome

☐ Depression ☐ Interstitial Cystitis ☐ Pain syndromes

☐ Endometriosis ☐ GYN cancers ☐ Substance abuse

☐ Other cancer type ____________ ☐ Other chronic condition ____________

Patient Label

Surgical History (use a separate sheet of paper if needed)

Please list all surgical procedures you have had **related to this pain**.

Year	*Procedure*	*Surgeon*	*Findings*

Please list all **other** surgical procedures:

Year	*Procedure*	*Surgeon*	*Findings*

Medications (use a separate sheet of paper if needed)

Please list **pain medication** you have taken for your pain condition **in the past 6 months**, and the providers who prescribed them.

Medication & Dose	*Provider*	*Did it help?*
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking
		☐ Yes ☐ No ☐ Currently taking

Please list all **other medications** you are presently taking, the condition, and the provider who prescribed them.

Medication & Dose	*Medical Condition*	*Provider*

Medical History

Please list any medical problems/diagnoses ______________________________

____

____

Allergies (including latex allergy) ______________________________

Who is your Primary Care Provider? Name: ______________________________

Have you ever been hospitalized for anything besides childbirth or the surgeries listed above? ☐ No ☐ Yes If yes, explain

____

____

Have you had major accidents such as falls or a back injury? ☐ No ☐ Yes

Have you ever been treated for depression? ☐ No ☐ Yes Treatments: ☐ Medication ☐ Hospitalization ☐ Psychotherapy

Birth control method: ☐ Nothing ☐ Pill ☐ Vaginal Ring ☐ Depo-Provera ☐ Condom ☐ IUD

☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization ☐ Vasectomy ☐ Other: ______________

Patient Label

Menstrual History

How old were you when your menses started? _____ Are you still having menstrual periods? ☐ No ☐ Yes

Answer the following only if you are still having menstrual periods.

Periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Bleeding through protection

How many days between your periods? __________

How many days of menstrual flow? ____________

Date of first day of last menstrual period: _______________

Are your periods regular? ☐ No ☐ Yes

Do you have any pain with your periods? ☐ No ☐ Yes

Does pain start the day flow starts? ☐ No ☐ Yes Pain starts ___________ days before flow.

Do you pass clots in menstrual flow? ☐ No ☐ Yes

Obstetric History

How many pregnancies have you had? _____

Resulting in (#): _____Full 9 months _____Premature _____Miscarriage/Abortion _____Living Children

Where there any complications during pregnancy, labor, delivery, or post-partum?

☐ 4^0 Episiotomy ☐ C-Section ☐ Vacuum ☐ Post-partum hemorrhaging

☐ Vaginal laceration ☐ Forceps ☐ Medications for bleeding ☐ Other ____________________

Gastrointestinal / Eating

Do you have nausea? ☐ No ☐ With pain ☐ Taking medications ☐ With eating ☐ Other __________________

Do you have vomiting? ☐ No ☐ With pain ☐ Taking medications ☐ With eating ☐ Other __________________

Have you ever had an eating disorder such as anorexia or bulimia? ☐ No ☐ Yes

Are you experiencing rectal bleeding or blood in your stool? ☐ No ☐ Yes

Do you have increased pain with bowel movements? ☐ No ☐ Yes

The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition which may be the cause of pelvic pain. **Do you have pain or discomfort that is associated with the following?**

Change in frequency of bowel movements? ☐ No ☐ Yes

Change in appearance of stool or bowel movements? ☐ No ☐ Yes

Does your pain improve after completing a bowel movement? ☐ No ☐ Yes

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, etc.) ☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

How many cigarettes do you smoke per day? ______ For how many years? _________

Do you drink alcohol? ☐ No ☐ Yes If yes, number of drinks per week ____________

Have you ever received treatment for substance abuse? ☐ No ☐ Yes

What is your use of recreational drugs? ☐ Never used ☐ Used in the past, but not now ☐ Presently using ☐ No answer

☐ Heroin ☐ Amphetamines ☐ Marijuana ☐ Barbiturates ☐ Cocaine ☐ Other: __________________________

How would you describe your diet? (check all the apply)

☐ Well balanced ☐ Vegan ☐ Vegetarian ☐ Fried Food ☐ Special Diet: ______________________________

How many hours of sleep do you typically get each night? _________ hours

Patient Label

Urinary Symptoms

Do you experience any of the following?

Loss of urine when coughing, sneezing, or laughing?	□ No	□ Yes
Difficulty passing urine?	□ No	□ Yes
Frequent bladder infections?	□ No	□ Yes
Blood in the urine?	□ No	□ Yes
Bladder still feeling full after urination?	□ No	□ Yes
Having to void again within minutes of voiding?	□ No	□ Yes

The following questions help to diagnose Painful Bladder Syndrome, which may cause pelvic pain.

Please CIRCLE the answer that best describes your bladder function and symptoms.

How many times do you go to the bathroom **DURING THE DAY** (to void or empty your bladder)?	3-6	7-10	11-14	15-19	20 or more
How many times do you go to the bathroom **AT NIGHT** (to void or empty your bladder)?	0	1	2	3	4 or more
If you get up at night to void or empty your bladder, does it bother you?	Never	Mildly	Moderately	Severely	
Are you sexually active?	No	Yes			
If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always	
If you have pain with intercourse, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always	
Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?	Never	Occasionally	Usually	Always	
Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
If you have pain, is it usually	Never	Mild	Moderate	Severe	
Does your pain bother you?	Never	Occasionally	Usually	Always	
If you have urgency, is it usually	Never	Mild	Moderate	Severe	
Does your urgency bother you?	Never	Occasionally	Usually	Always	

The following questions help to diagnose Pelvic Varicosity Pain Syndrome, which may cause pelvic pain.

Is your pelvic pain aggravated by prolonged physical activity?	□ No	□ Yes
Does your pelvic pain improve when you lie down?	□ No	□ Yes
Do you have pain that is deep in the vagina or pelvis *during* sex?	□ No	□ Yes
Do you have pelvic throbbing or aching *after* sex?	□ No	□ Yes
Do you have pelvic pain that moves from side to side?	□ No	□ Yes
Do you have sudden episodes of severe pelvic pain that come and go?	□ No	□ Yes

Patient Label

Coping Mechanisms

Who are the people you talk to concerning your pain, or during stressful times?

☐ Spouse/Partner ☐ Relative ☐ Support Group ☐ Clergy
☐ Doctor/Nurse ☐ Friend ☐ Mental Health provider ☐ I take care of myself

How does your partner deal with your pain?

☐ Not applicable ☐ Doesn't notice when I'm in pain ☐ Takes care of me ☐ Withdraws
☐ Feels helpless ☐ Distracts me with activities ☐ Gets angry

What helps your pain?

☐ Meditation ☐ Relaxation ☐ Lying down ☐ Music ☐ Massage
☐ Ice ☐ Heating Pad ☐ Hot bath ☐ Pain medication ☐ Laxatives/Enema
☐ Injection ☐ TENS unit ☐ Bowel movement ☐ Emptying bladder ☐ Nothing
☐ Other: ______________________________

What makes your pain worse?

☐ Intercourse ☐ Orgasm ☐ Stress ☐ Full meal ☐ Bowel movement
☐ Full bladder ☐ Urination ☐ Standing ☐ Walking ☐ Exercise
☐ Time of day ☐ Weather ☐ Contact with clothing ☐ Coughing/Sneezing ☐ Not related to anything
☐ Other: ______________________________

Over the **LAST 2 WEEKS**, how often have you been bothered by feeling nervous, anxious or on edge?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Over the **LAST 2 WEEKS**, how often have you been bothered by not being able to stop or control worrying?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Over the **LAST 2 WEEKS**, how often have you been bothered by little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Over the **LAST 2 WEEKS**, how often have you been bothered by feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Please put a **check mark** in the column that represents the degree to which you feel the following.

When I'm in pain....	Not at all (0)	To a slight degree (1)	To a moderate degree (2)	To a great degree (3)	All the time (4)
I worry all the time about whether the pain will end.					
I feel I can't go on.					
It's terrible and I think it's never going to get any better.					
It's awful and I feel it overwhelms me.					
I feel I can't stand it anymore.					
I become afraid that the pain will get worse.					
I keep thinking of other painful events.					
I anxiously want the pain to go away.					
I can't seem to keep it out of my mind.					
I keep thinking about how much it hurts.					
I keep thinking about how badly I want the pain to stop.					
There's nothing I can do to reduce the intensity of the pain.					
I wonder whether something serious may happen.					

Patient Label

Sexual and Physical Abuse History

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted. ☐ No ☐ Yes ☐ No Answer

Check the answer for **both** as a child and as an adult.	As a Child (13 and younger)		As an Adult (14 and over)	
Has anyone ever exposed the sex organs of their body to you when you did not want it?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone ever threatened to have sex with you when you did not want it?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone ever touched the sex organs of your body when you did not want this?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone ever made you touch the sex organs of their body when you did not want this?	☐ No	☐ Yes	☐ No	☐ Yes
Has anyone forced you to have sex when you did not want this?	☐ No	☐ Yes	☐ No	☐ Yes
Have you had any other unwanted sexual experiences not mentioned above?	☐ No	☐ Yes	☐ No	☐ Yes

If yes, please explain ____________________

When you were a child (13 or younger), did an older person do the following?

Hit, kick, or beat you?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often
Seriously threaten your life?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often

When you were an adult (14 or older), has any other adult done the following?

Hit, kick, or beat you?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often
Seriously threatened your life?	☐ Never	☐ Seldom	☐ Occasionally	☐ Often

Currently:

Is anyone close to you threatening to hurt you? ☐ Yes ☐ No

Is anyone hitting, kicking, choking, or hurting you physically? ☐ Yes ☐ No

Is anyone forcing you to do something sexually that you do not want to do? ☐ Yes ☐ No

The words below describe average pain. Please put a **check mark** in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of **the pain in your pelvic area only**.

What does your pain feel like?

Type	None (0)	Mild (1)	Moderate (2)	Severe (3)
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot/Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring/Exhausting				
Sickening				
Fearful				
Punishing/Cruel				

Thank you for completing this questionnaire.

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(205) 877-2950 www.pelvic pain.org (800)624-9676 (if in the U.S.)