CENTER FOR SPECIAL MINIMIALLY INVASIVE AND ROBOTIC SURGERY
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Pelvic Pain Assessment Form

Initial History *Date:*_____

Contact Information

Name: _____Birth Date:_____Email:_____
Please join us on Facebook
Phone: Work: _____ Home: _____ Cell: _____
Home Address:
_____
SSN:
Referring Provider's Name and Address: _____
Emergency Contact and Phone number:
_____

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? Yes No If so, what? _____
How long have you had this pain? ____years ____months

For each of the symptoms listed below, please "bubble in" your level of pain over the last month using a 10-point scale:
0 - no pain 10 – the worst pain imaginable

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

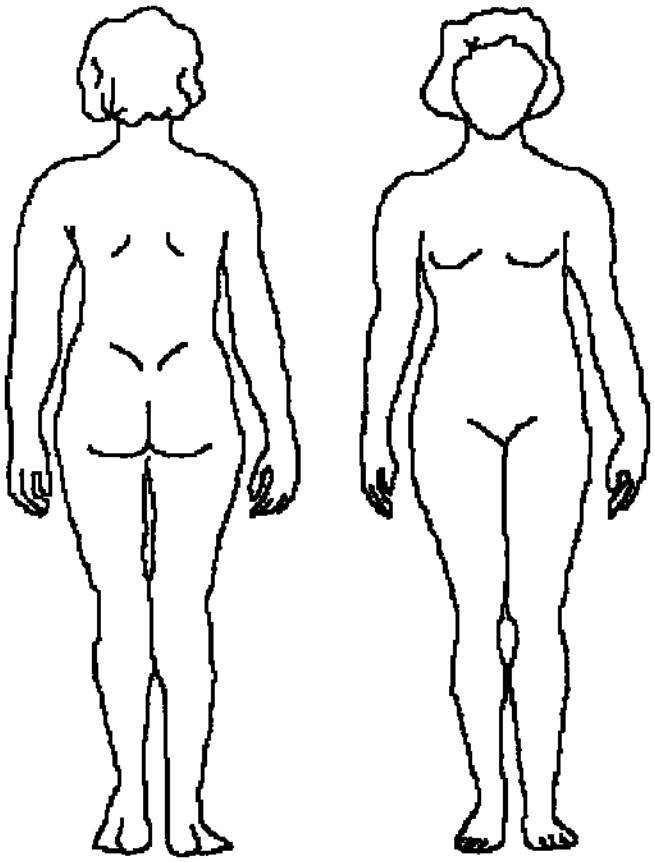
Information About Your Pain

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

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

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)



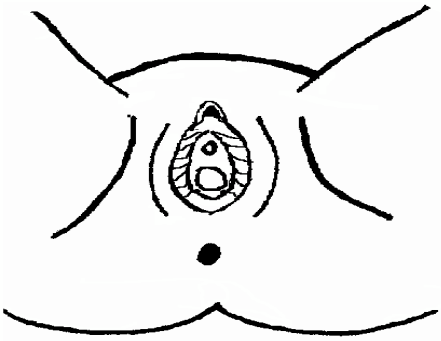
Left Right Right Left

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

Right Left



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

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

Demographic Information

Are you (check all that apply):

Married Widowed Separated Committed Relationship
Single Remarried Divorced

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? _____

Surgical History

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

Year	Procedure	Surgeon	Findings

Please list all **other** surgical procedures:

Year	Procedure

Year	Procedure

Provider Comments

_____

_____

_____

_____

Medications

Please list **pain medication** you have taken for your pain condition in the past 6 months, and the providers who prescribed them (use a separate page if needed):

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
		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 (use a separate page if needed):

Medication / dose	Provider	Medical Condition

Obstetrical 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° Episiotomy	C-Section	Vacuum	Post-partum hemorrhaging
Vaginal laceration	Forceps	Medication for bleeding	Other _____

Family History

Has anyone in your family had:

Fibromyalgia	Chronic pelvic pain	Irritable bowel syndrome
Depression	Interstitial Cystitis	Other Chronic Condition _____
Endometriosis	Cancer, Type(s) _____	

Please indicate which family member affected

Medical History

Please list any medical problems / diagnoses _____

Have you had any of the following:
- Unexplained and sudden weight loss or gain
- Fever
- Fatigue
- Hot flashes/night sweats
- Shortness of breath
- Palpitations
- Chest pain
- Depression/Crying
- Anxiety
- Insomnia
- Other

Allergies (Please list ALL Alergies including latex allergy)

Who is your primary care provider?
Address: **Phone#** **Fax#**

What Pharmacy do you use?
Address: **Phone#** **Fax#**

Have you ever been hospitalized for anything besides childbirth? Yes No If yes, please explain

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

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

Birth control method: Nothing Pill Vasectomy Vaginal ring Depo provera
Condom IUD Hysterectomy Diaphragm Tubal Sterilization
Other _____

Last PAP smear / / Results
* Do you have history of abnormal pap? Y N Result/Treatment

- Have you ever had :
- Chlamydia When?
- Herpes When?
- Gonorrhea When?
- Condyloma (warts) When?
- Exposure to HIV? When?

Have you had the Gardasil Injection? Y N

Last Mammogram / /_ Results
* Do you have history of abnormal mammogram? Y N Results/Treatment
* Do you perform your own self breast exams every month? Y N

Have you ever had an endometrial biopsy done? Y N If so, when/results

Have you ever had a colorectal screening? Y N If so, when/results

Menstrual History

How old were you when your menses started? _____

Are you still having menstrual periods? Yes No

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

Periods are: Light Moderate Heavy Bleed through protection

How many days between your periods? _____

How many days of menstrual flow? _____

Date of first day of last menstrual period _____

Do you have any pain with your periods? Yes No

Does pain start the day flow starts? Yes No Pain starts _____days before flow

Are periods regular? Yes No

Do you pass clots in menstrual flow? Yes No

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? Yes No

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

Do you have increased pain with bowel movements? Yes No

The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain.

Do you have pain or discomfort that is associated with the following:

Change in frequency of bowel movement Yes No

Change in appearance of stool or bowel movement? Yes No

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

Health Habits

How often do you exercise? Rarely 1-2 times weekly 3-5 times weekly Daily

What is your caffeine intake (number 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? Yes No

Number of drinks per week _____

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 No answer

Heroin Amphetamines Marijuana Barbiturates Cocaine Other _____

How would you describe your diet? (check all that apply) Well balanced Vegan Vegetarian Fried food

Special diet _____ Other _____

Urinary Symptoms

Do you experience any of the following?

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

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.

	0	1	2	3	4
1. 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
2. How many times do you go to the bathroom **AT NIGHT** (to void or empty your bladder)?	0	1	2	3	4 or more
3. If you get up at night to void or empty your bladder does it bother you?	Never	Mildly	Moderately	Severely	
4. Are you sexually active? Yes No					
5. 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	
6. If you have pain with intercourse, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always	
7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?	Never	Occasionally	Usually	Always	
8. Do you have urgency after voiding?	Never	Occasionally	Usually	Always	
9. If you have pain, is it usually	Never	Mild	Moderate	Severe	
10. Does your pain bother you?	Never	Occasionally	Usually	Always	
11. If you have urgency, is it usually		Mild	Moderate	Severe	
12. Does your urgency bother you?	Never	Occasionally	Usually	Always	

10-14 = 75% + PCT
15-19 = 76% + PCT
>20 = 91% + PST

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?

Doesn't notice when I'm in pain	Takes care of me	Not applicable
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 _____			

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

The most important problem Just one of many problems

Sexual and Physical Abuse History

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

Check an answer for both as a child and as an adult.	As a child (13 and younger)		As an adult (14 and over)	
1a. Has anyone ever exposed the sex organs of their body to you when you did not want it?	Yes	No	Yes	No
1b. Has anyone ever threatened to have sex with you when you did not want it?	Yes	No	Yes	No
1c. Has anyone ever touched the sex organs of your body when you did not want this?	Yes	No	Yes	No
1d. Has anyone ever made you touch the sex organs of their body when you did not want this?	Yes	No	Yes	No
1e. Has anyone forced you to have sex when you did not want this?	Yes	No	Yes	No
1f. Have you had any other unwanted sexual experiences not mentioned above?	Yes	No	Yes	No

If yes, please specify _____

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

a. Hit, kick, or beat you?	Never	Seldom	Occasionally	Often
b. Seriously threaten your life?	Never	Seldom	Occasionally	Often

3. Now that you are an adult (14 or older), has any other adult done the following?

a. Hit, kick, or beat you?	Never	Seldom	Occasionally	Often
b. Seriously threaten your life?	Never	Seldom	Occasionally	Often

Leserman, J, Drossman D, Li Z. The reliability and validity of a sexual and physical abuse history questionnaire in female patients with gastrointestinal disorders. Behavioral Medicine 1995;21:141-148.

Short-Form McGill

The words below describe average pain. Place 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				

Melzak R. The Short-form McGill Pain Questionnaire. Pain 1987;30:191-197.

Pelvic Varicosity Pain Syndrome Questions

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

Fertility History

Do you intend to get pregnant? Y N

When do you plan to try? _____

How long have you and your partner been attempting pregnancy? _____

Have you been treated for infertility previously? Y N

If yes, where and when? _____

Which tests have been performed?

- o Basal body temperature
- o Infection test (ureaplasma, mycoplasma)
- o Estradiol
- o Post coital test
- o Endometrial biopsy
- o FSH
- o Clomid challenge test
- o Hysterosalpingogram
- o DHEAS
- o Sonohysterogram
- o Antibody tests
- o Thyroid
- o Testosterone
- o Ultrasound

Have you ever taken any of the following?

- o Clomid
- o Letrazole
- o HcG (Ovidrel)
- o Injectible Gonoadotropins
- o Progesterones
- o Progestins
- o Estrogen
- o Testosterone

Have you ever attempted intrauterine insemination? Y N

If yes, how many times:

Dates:

Was specimen provided by • Donor • Partner

Have you ever attempted in vitro fertilization? Y N

If yes, how many times? _____

Has your male partner had any of the following tests done?

- o Semen analysis
- o Chromosome test
- o Chlamydia
- o Testicular biopsy
- o Hormonal test
- o Xray of testes

Has your male partner ever had surgery involving the reproductive tract?

- o Varicocele repair
- o Vasectomy
- o Vasectomy reversal
- o Hernia repair
- o Repair of obstruction of vas deferens
- o Prostate surgery
- o Hernia repair
- o Testicular torsion repair

Has your male partner ever had significant testicular injury? Y N

If yes, explain _____

Patient history reviewed by Dr. _____

Physician signature: _____

Date: _____