



CENTER FOR  
ADVANCED GYNECOLOGY

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## Pelvic Pain History

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Referring Provider's Name/ Practice (if applicable) \_\_\_\_\_

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)                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain just before period                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Level of cramps with period                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain after period is over                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain with partner insertion (vaginal)               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Deep pain with intercourse                          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Burning vaginal pain after sex                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pelvic pain lasting hours or days after intercourse | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain with urination                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain when bladder is full                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain in groin when lifting                          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Muscle / joint pain                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Backache  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Migraine headache                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pain with Sitting                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

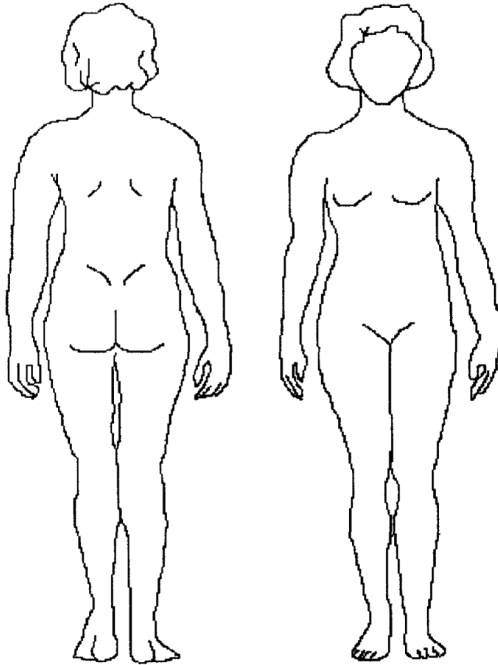
The words below describe average pain. Mark (X) in the column which represents the degree you feel that type of pain. Limit yourself to a description of the pain in your pelvic area only.

|                  | None  | Mild  | Moderate | Severe |                    | None  | Mild  | Moderate | Severe |
|------------------|-------|-------|----------|--------|--------------------|-------|-------|----------|--------|
| <b>Throbbing</b> | _____ | _____ | _____    | _____  | <b>Heavy</b>       | _____ | _____ | _____    | _____  |
| <b>Shooting</b>  | _____ | _____ | _____    | _____  | <b>Tender</b>      | _____ | _____ | _____    | _____  |
| <b>Stabbing</b>  | _____ | _____ | _____    | _____  | <b>Aching</b>      | _____ | _____ | _____    | _____  |
| <b>Sharp</b>     | _____ | _____ | _____    | _____  | <b>Gnawing</b>     | _____ | _____ | _____    | _____  |
| <b>Cramping</b>  | _____ | _____ | _____    | _____  | <b>Hot-Burning</b> | _____ | _____ | _____    | _____  |

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

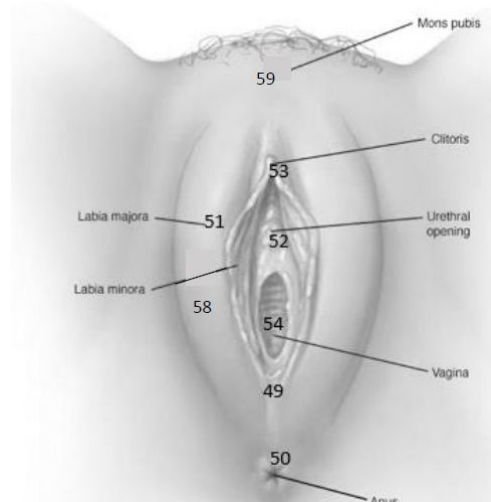
**Pain Map**

Please shade or circle 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 & around the vagina & anus)**

If you have pain in this area, is your pain RELIEVED by sitting on a commode/toilet seat?  Yes  No



Right

Left

**What helps your pain? (circle)**

|                     |                  |            |                 |                 |
|---------------------|------------------|------------|-----------------|-----------------|
| Meditation          | Relaxation       | Lying down | Massage         | TENS unit       |
| Ice                 | Heating Pad      | Hot Bath   | Pain Medication | Laxatives/Enema |
| Bowel Movement      | Emptying Bladder | Nothing    |                 |                 |
| <b>Other:</b> _____ |                  |            |                 |                 |

**What makes your pain worse? (circle)**

|                     |                |                     |                     |                |
|---------------------|----------------|---------------------|---------------------|----------------|
| Intercourse         | Orgasm         | Stress              | Full Meal           | Bowel Movement |
| Full Bladder        | Urination      | Standing            | Walking             | Exercise       |
| Time of Day: _____  | Weather: _____ | Contact w/ Clothing | Coughing / Sneezing | Nothing        |
| <b>Other:</b> _____ |                |                     |                     |                |

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

|              |                                    |                 |                     |                         |
|--------------|------------------------------------|-----------------|---------------------|-------------------------|
| Acupuncture  | Anti-seizure med                   | Antidepressants | Biofeedback         | Botox injection         |
| CBD oil      | Contraceptive pills / patch / ring | Depo-provera    | Herbal Medicine     | Homeopathic medicine    |
| Lupron       | Massage                            | Meditation      | Narcotics / Opioids | Naturopathic medication |
| Nerve blocks | Nutrition / diet                   | Orilissa        | Physical Therapy    | Therapist/counseling    |
| TENS unit    | Trigger point injections           |                 | Gastroenterologist  | Gynecologist            |
| Neurosurgeon | Pain Specialist                    | Psychiatrist    | Rheumatologist      | Urologist               |

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? ----- Y    N

Are you experiencing rectal bleeding or blood in your stool? ----- Y    N

Do you have increased pain with bowel movements? ----- Y    N

Do you experience significant constipation? ----- Y    N

Do you experience frequent diarrhea? ----- Y    N

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

Change in frequency of bowel movement? ----- Y    N

Change in appearance of stool or bowel movement? ----- Y    N

Does your pain improve after completing a bowel movement? ----- Y    N

**Urinary Symptoms**

Loss of urine when coughing, sneezing or laughing? ----- Y N  
Blood in the urine? ----- Y N

**During the past month, how often have you felt the strong need to urinate with little or no warning?**

- 0. \_\_\_ not at all
- 1. \_\_\_ less than 1 time in 5
- 2. \_\_\_ less than half the time
- 3. \_\_\_ about half the time
- 4. \_\_\_ more than half the time

**During the past month, have you had to urinate less than 2 hours after you finished urinating?**

- 0. \_\_\_ not at all
- 1. \_\_\_ less than 1 time in 5
- 2. \_\_\_ less than half the time
- 3. \_\_\_ about half the time
- 4. \_\_\_ more than half the time

**During the past month, how often did you most typically get up at night to urinate?**

- 0. \_\_\_ never
- 1. \_\_\_ once
- 2. \_\_\_ 2 times
- 3. \_\_\_ 3 times
- 4. \_\_\_ 4 times
- 5. \_\_\_ 5 times
- 6. \_\_\_ 5 or more times

**During the past month, have you experienced pain or burning in your bladder?**

- 0. \_\_\_ not at all
- 1. \_\_\_ once
- 2. \_\_\_ a few times
- 3. \_\_\_ fairly often
- 4. \_\_\_ almost always
- 5. \_\_\_ usually

**TOTAL** \_\_\_\_\_

**During the past month, how much has each of the following been a problem for you?**

**Frequent urination during the day?**

- 0. \_\_\_ no problem
- 1. \_\_\_ very small problem
- 2. \_\_\_ small problem
- 3. \_\_\_ medium problem
- 4. \_\_\_ big problem

**Getting up at night to urinate?**

- 0. \_\_\_ no problem
- 1. \_\_\_ very small problem
- 2. \_\_\_ small problem
- 3. \_\_\_ medium problem
- 4. \_\_\_ big problem

**Need to urinate with little warning?**

- 0. \_\_\_ no problem
- 1. \_\_\_ very small problem
- 2. \_\_\_ small problem
- 3. \_\_\_ medium problem
- 4. \_\_\_ big problem

**Burning, pain, discomfort, or pressure in your bladder?**

- 0. \_\_\_ no problem
- 1. \_\_\_ very small problem
- 2. \_\_\_ small problem
- 3. \_\_\_ medium problem
- 4. \_\_\_ big problem

**TOTAL** \_\_\_\_\_

>6; >12 ; O'Leary, Sant et al Urology 1997; 49(Suppl. 5A): 58-63

**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<br>(13 and younger) |   | As an adult<br>(14 and over) |   |
|---|--------------------------------|---|------------------------------|---|
|   | Y                              | N | Y                            | N |
| 1a. Has anyone ever exposed the sex organs of their body to you when you did not want it?   | Y                              | N | Y                            | N |
| 1b. Has anyone ever threatened to have sex with you when you did not want it?               | Y                              | N | Y                            | N |
| 1c. Has anyone ever touched the sex organs of your body when you did not want this?         | Y                              | N | Y                            | N |
| 1d. Has anyone ever made you touch the sex organs of their body when you did not want this? | Y                              | N | Y                            | N |
| 1e. Has anyone forced you to have sex when you did not want this?                           | Y                              | N | Y                            | N |
| 1f. Have you had any other unwanted sexual experiences not mentioned above?                 | Y                              | N | Y                            | N |

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.*

## Pain Catastrophizing Scale

Sullivan MJL, Bishop S, Pivik J. (1995)

**Date:** \_\_\_\_\_

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

*Instructions:*

*We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.*

| RATING  | 0          | 1                  | 2                    | 3                 | 4            |
|---------|------------|--------------------|----------------------|-------------------|--------------|
| MEANING | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |

***When I'm in pain ...***

| Number | Statement  | Rating |
|--------|--|--------|
| 1      | I worry all the time about whether the pain will end.        |        |
| 2      | I feel I can't go on.  |        |
| 3      | It's terrible and I think it's never going to get any better |        |
| 4      | It's awful and I feel that it overwhelms me.                 |        |
| 5      | I feel I can't stand it anymore                              |        |
| 6      | I become afraid that the pain will get worse.                |        |
| 7      | I keep thinking of other painful events                      |        |
| 8      | I anxiously want the pain to go away                         |        |
| 9      | I can't seem to keep it out of my mind                       |        |
| 10     | I keep thinking about how much it hurts.                     |        |
| 11     | I keep thinking about how badly I want the pain to stop      |        |
| 12     | There's nothing I can do to reduce the intensity of the pain |        |
| 13     | I wonder whether something serious may happen.               |        |

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Source: Sullivan MJL, Bishop S, Pivik J. The pain catastrophizing scale: development and validation. Psychol Assess, 1995, 7: 524-532

Total: \_\_\_\_ / \_\_\_\_ %ile