THE INTERNATIONAL PELVIC PAIN SOCIETY

Patient History Date: _____

This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

Contact Information

Name: _____ Birth Date: _____

Referring Provider's Name and 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? 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

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.

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	

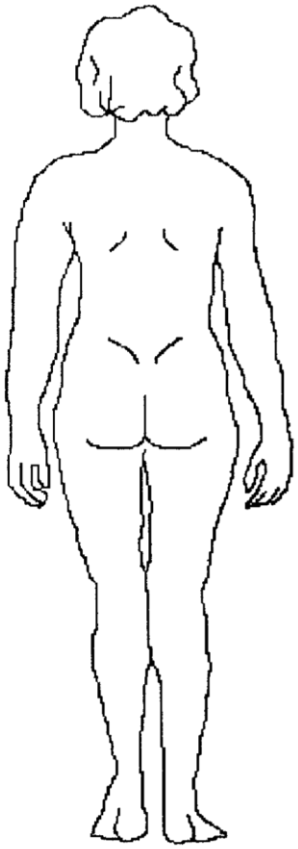
Other _____

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

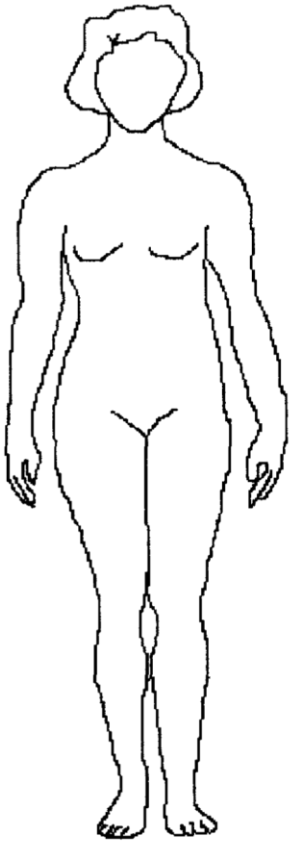
Acupuncture	Family Practitioner	Nutrition / diet
Anesthesiologist	Herbal Medicine	Physical Therapy
Anti-seizure medications	Homeopathic medicine	Psychotherapy
Antidepressants	Lupron	Psychiatrist
Biofeedback	Massage	Rheumatologist
Botox injection	Meditation	Skin magnets
Contraceptive pills / patch / ring	Narcotics	Surgery
Danazol (Danocrine)	Naturopathic medication	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



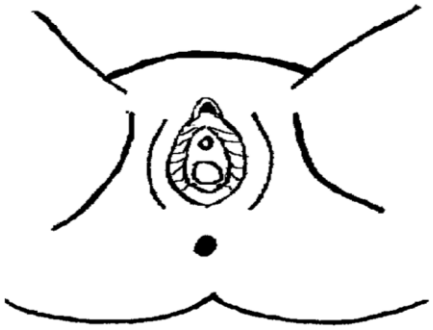
Right Left

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



Gynecologic History

Age when periods 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 bleeding? _____

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

Have you ever had chlamydia, gonorrhea or pelvic inflammatory disease (PID)? Yes No

If yes, which infection and what year?_____

Have you ever had an abnormal pap smear? Yes No

When was your last pap smear and what was the result? Date:_____ normal abnormal

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 _____

Gastrointestinal / Eating

Nausea?	No	With pain	Taking medications	With eating	Other
Vomiting?	No	With pain	Taking medications	With eating	Other

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

Current rectal bleeding or blood in stool? Yes No

Increased pain with bowel movements? Yes No

Do you have pain or discomfort associated with:

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

Urinary 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?	Yes	No			
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			
Urgency to void?	Yes	No			
Pain associated with your bladder?	Yes	No			

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?

_____

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

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

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

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

Medical History

Please list any medical problems / diagnoses

_____

_____

_____

Allergies (including latex allergy)

_____

Who is your primary care provider?

_____

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

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

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 foods?
Special diet _____ Other _____

Family History

Has anyone in your family had:	Fibromyalgia	Chronic pelvic pain	Irritable bowel syndrome
	Depression	Endometriosis	Interstitial Cystitis
		Other Chronic Condition:	_____
	Ovarian Cancer	Breast Cancer	Colon Cancer
	Endometrial Cancer	Other Cancer, Type(s):	_____

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	

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.

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 our 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.	

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