CENTER FOR
ADVANCED GYNECOLOGY

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Pelvic Pain History

Date: _____ Name: _____ Birth Date: _____

Referring Provider's Name & Address (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)	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
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
Pain with partner insertion (vaginal)	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
Burning vaginal pain after sex	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 with urination	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
Pain in groin when lifting	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
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

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
Throbbing	_____	_____	_____	_____	**Heavy**	_____	_____	_____	_____
Shooting	_____	_____	_____	_____	**Tender**	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____	**Aching**	_____	_____	_____	_____
Sharp	_____	_____	_____	_____	**Gnawing**	_____	_____	_____	_____
Cramping	_____	_____	_____	_____	**Hot-Burning**	_____	_____	_____	_____

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

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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		
Other: _____				

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
Other: _____				

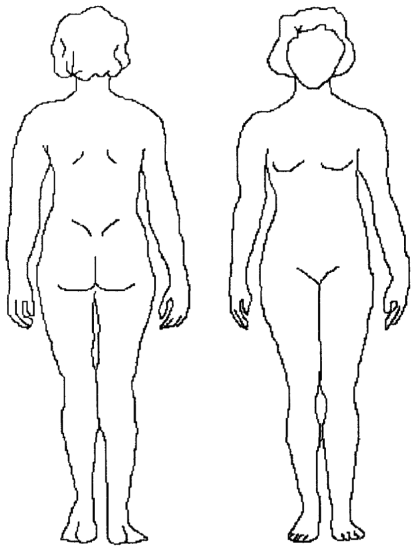
What types of treatments / providers have you tried in the past for your pain? Please circle all that apply.

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	Physical Therapy	Therapist/counseling	TENS unit
Trigger point injections			Gastroenterologist	Gynecologist
Neurosurgeon	Pain Specialist	Psychiatrist	Rheumatologist	Urologist

Other: _____

Pain Map

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



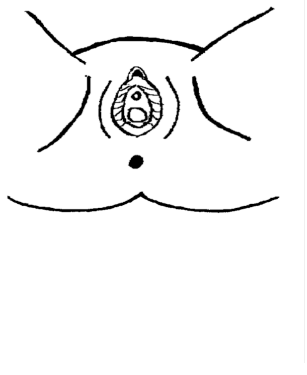
Left Right

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



Right Left

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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
	Y	N

Urinary Symptoms

Do you experience:

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 l 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 l 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

Coping Mechanisms (circle all that apply)

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
Feels Helpless	Distracts me with activities	Gets angry
Withdraws		

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?	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.

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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.	

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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