THE INTERNATIONAL PELVIC PAIN SOCIETY

Pelvic Pain Assessment Form

Physician: _____

Initial History and Physical Examination *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:_____ Chart Number:_____

Phone: Work: _____ Home: _____ Cell: _____

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

Provider Comments

_____

_____

_____

_____

_____

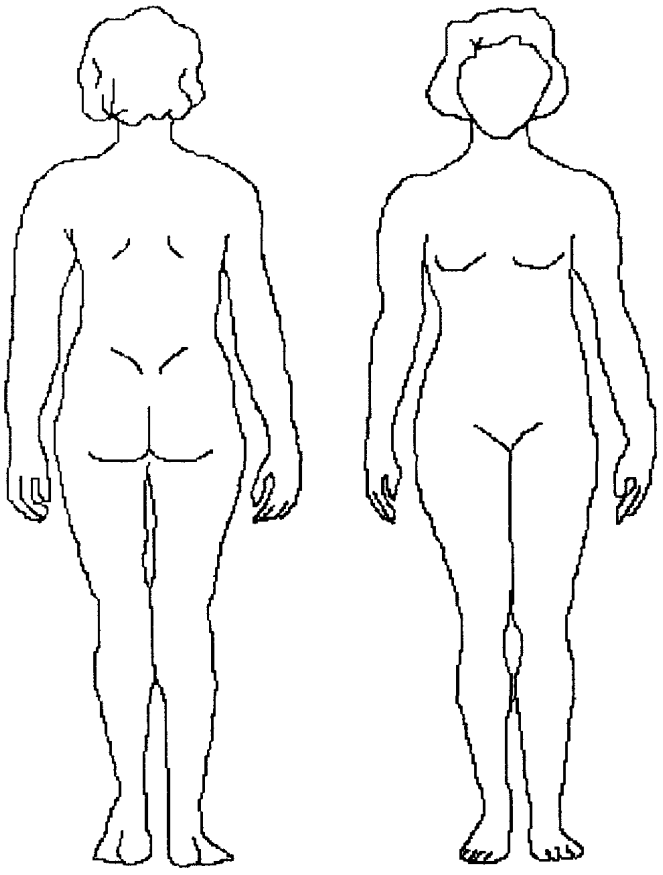
Information About Your Pain

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)



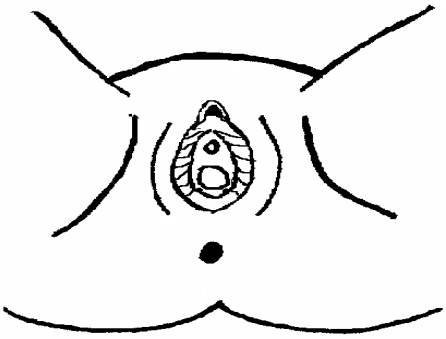
Left Right Right Left

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) _____

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

Birth control method: ☐ Nothing ☐ Pill ☐ Vasectomy ☐ Vaginal ring ☐ Depo provera

☐ Condom ☐ IUD ☐ Hysterectomy ☐ Diaphragm ☐ Tubal Sterilization

☐ Other _____

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	

KCl ____ Not Indicated ____ Positive ____ Negative

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 <u>both</u> 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