Patient Name	Date of Birth	Patient ID

Today's Date:

Initial Questionnaire

Allergies

List all known allergies.

Allergy ____________________ Reaction(s)

____________________ ____________________ ___ / ______

____________________ ____________________ ___ / ______

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Social History

1. Smoking Status (Circle one)

Never smoker   Former smoker   Current every day smoker   Current some day smoker

Smoker - current status unknown   Unknown if ever smoked

2. Smoking - How much? (Circle one)

None	1 PPW	2 PPW	1/4 PPD
1/2 PPD	1 PPD	1 1/2 PPD	2 PPD
3+ PPD			

3. Occupation ______________________________

4. General stress level (Circle one)

Low Medium High

5. Exercise level (Circle one)

None Occasional Moderate Heavy

6. Relationship Status (Circle one)

Unknown	Married	Single	Divorced
Separated	Widowed	Domestic Partner	Other

7. Number of children (Circle one)

0	1	2	3
4	5	6	7
8	9+		

8. Sexually active? (Circle one)

Yes No

9. Sexual orientation (Circle one)

Heterosexual Homosexual Bisexual

10. Protected sex? (Circle one)

Always Usually No

11. Have you ever had unprotected intercourse for six months or longer? (Circle one)

Yes No

12. Do you have a history of abuse? (Circle one)

Emotionally Physically Sexually I was NOT abused

13. Age at time of Sexual of Abuse

____

14. Please rate the quality of life as you are experiencing it now: (Circle one)

Awful Poor Fair Good

Terrific

Surgical History

Check all surgeries that apply.

- ☐ Abdominoplasty
- ☐ Appendectomy
- ☐ Bilateral Mastectomy
- ☐ Breast Biopsy
- ☐ Breast Implants
- ☐ Breast Surgery
- ☐ Caesarean Section
- ☐ Cardiac Surgery
- ☐ Cataract Surgery
- ☐ Cholecystectomy
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Coronary Artery Bypass
- ☐ Cryotherapy/Cryocautery
- ☐ Cystoscopy
- ☐ Dilation and Curettage
- ☐ Ear Tube
- ☐ Ectopic Pregnancy
- ☐ Endometrial Ablation
- ☐ Endometrial Biopsy
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Hysteroscopy
- ☐ LEEP
- ☐ Laparoscopy
- ☐ Laparotomy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Oophorectomy
- ☐ Orthopedic Surgery
- ☐ Other
- ☐ Ovarian Cystectomy
- ☐ Partial Hysterectomy
- ☐ Thyroid Surgery
- ☐ Total Colectomy
- ☐ Total Hysterectomy
- ☐ Tubal Ligation
- ☐ cystocele repair
- ☐ Endometriosis Excision
- ☐ rectocele repair

- ☐ Ablation of Endometriosis
- ☐ Extracorporeal Shock Wave Lithotripsy (ESWL)
- ☐ Flexible Sigmoidoscopy
- ☐ Gastric Bypass
- ☐ sacrocolpopexy
- ☐ sling
- ☐ tonsilectomy/adenoids

Pain History/Symptoms

1. Are you doubling over in pain, or lying down in pain, during your period? (Circle one)

   Yes No

2. Have you had to miss school or work due to pelvic pain? (Circle one)

   Yes No

3. Have you been to the Emergency Room for pelvic pain, but have not been given a specific diagnosis? (Circle one)

   Yes No

4. Have you had to, or do you now, take narcotics for pelvic pain? (Circle one)

   Yes No

5. Did your mother have, or do you have a sister with, endometriosis? (Circle one)

   Yes No

6. Have you had previous surgery or diagnostic laparoscopy for pelvic pain or for infertility? (Circle one)

   Yes No

7. If YES, at what age was your first surgery?

   ____

8. If YES, how many surgeries have you had?

   ____

9. If YES, please list as best as possible the month and year of each surgery:

   ____

10. What was the most severe stage of endometriosis found? (Circle one)

    None I II III

    IV Not Known

11. What type of treatment did you receive? (Circle one)

    None (diagnostic only) ablation/vaporization/cauterization/etc. excision medication

other

Hormonal Suppression

1. Have you ever been on hormonal suppression (examples include birth control pills, injections, GnRH, Mirena IUD) for pain with menstrual cramps? (Circle one)

   Yes No

2. If YES, at what age did you first use suppressive hormones?

   ____

3. If YES, what have you tried in the past (list all)?

   ____

4. If YES how many MONTHS total lifetime?

   ____

5. If YES what are the reasons? (Circle one)

   Pain Other Both

6. If NOT currently on hormonal suppression, when were you last on it?

   ____

GYN History

1. At what age did you begin to have periods? ________

2. When was the first day of your last period?

   ____ / ________

3. When was your last pap smear?

   ____ / ________

4. Have you ever had an abnormal pap smear? (Circle one)

   Yes No

5. When was your last mammogram?

   ____ / ________

6. When was your last Colonoscopy?

   ____ / ________

7. At what age did you begin to have pelvic pain symptoms?

   ____

8. Are you now or have you ever been sexually active? (Circle one)

   Yes No

9. Have you ever had a sexually transmitted disease (STD)? (Circle one)

Yes No

10. If YES, what did you have and when was it diagnosed?

11. When were you last tested negative for an STD?

Bowel Symptoms

1. I have been diagnosed with Endometriosis of the bowel: (Circle one)

Yes No

2. I have been diagnosed with IBS or other GI condition: (Circle one)

Yes No

3. How often do you have bowel movements? (Circle one)

Less than once a week One to three times a week Daily Several times a day

4. If you get up at night to go to the bathroom, does it bother you? (Circle one)

Never Mildly Moderately Severely

5. Sexually Active? (Circle one)

Yes No

6. If you are currently sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse? (Circle one)

Never Occasionally Usually Always

7. If you have pain, does it make you avoid sexual intercourse? (Circle one)

Never Occasionally Usually Always

8. Do you have pain associated with your bowel or in your pelvis (rectum, GI tract, etc.)? (Circle one)

Never Occasionally Usually Always

9. Do you have blood in stool? (Circle one)

Never Occasionally Usually Always

10. If you have pain with bowel movements, is it usuallyâ�¦ (Circle one)

Always Around my period In random

intervals

11. Does your pain bother you? (Circle one)

Never Occasionally Usually Always

12. If you have urgency to move your bowels, it is usuallyâ�¦ (Circle one)

Mild Moderate Severe

13. Does your urgency bother you? (Circle one)

Never Occasionally Usually Always

Bladder Symptoms

1. I have been diagnosed with Endometriosis of the bladder: (Circle one)

Yes No

2. I have been diagnosed with Interstitial Cystitis: (Circle one)

Yes No

3. How many times do you go to the bathroom during the day? (Circle one)

0-6 7 - 10 11- 14 15 - 19

20+

4. If you get up at night to go to the bathroom, does it bother you? (Circle one)

Never Mildly Moderately Severely

5. Sexually Active? (Circle one)

Yes No

6. If you are currently sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse? (Circle one)

Never Occasionally Usually Always

7. If you have pain, does it make you avoid sexual intercourse? (Circle one)

Never Occasionally Usually Always

8. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum)? (Circle one)

Never Occasionally Usually Always

9. Do you have urgency after going to the bathroom? (Circle one)

Never Occasionally Usually Always

10. If you have pain, is it usually…¦ (Circle one)

Mild Moderate Severe

11. Does your pain bother you? (Circle one)

Never Occasionally Usually Always

12. Does your urgency bother you? (Circle one)

Never Occasionally Usually Always

13. If you have urgency, it is usually…¦ (Circle one)

Never Occasionally Usually

Past Medical History

Check all diseases and conditions that apply.

- ☐ Abuse/Domestic Violence
- ☐ Acid Reflux (GERD)
- ☐ Acne
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects or Inherited Disease
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Breast Problem
- ☐ Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Kidney or Bladder Problems
- ☐ Lung Disease
- ☐ Menstrual Cramps
- ☐ Osteoporosis
- ☐ Other
- ☐ Ovarian Cancer
- ☐ Pelvic Pain
- ☐ Polyps

- ☐ Diverticulitis
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ GI Problems
- ☐ Headaches
- ☐ Pre-Eclampsia
- ☐ Psychiatric Illness
- ☐ Stroke
- ☐ Thrombophilias
- ☐ Thyroid Problems
- ☐ Varicosities
- ☐ Bipolar Disorder