INTERNATIONAL PELVIC PAIN SOCIETY

PELVIC HEALTH HISTORY FORM

www.pelvicpain.org

Today's Date: **Chart Number (FOR OFFICE USE ONLY):**

1. Contact information

Legal Last Name: **Legal First Name:**

Date of Birth: **Age:**

Email: **Phone:**

How do you prefer to be addressed? ***(Check all that apply)***

☐ She / Her ☐ He/Him ☐ Them/They ☐ Dr. ☐Legal last name ☐ Legal first name

☐Other Name: ☐Other gender pronoun:

What language do you prefer to communicate in? (*Check all that apply*)

☐English ☐Spanish ☐ French ☐Other:

2. Referring provider's name and contact information:

Name: **Phone:** **Contact address:**

How many doctors or health care providers have you seen in the past for your pelvic pain?

☐None ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐>10

3. Demographic information:

What race and ethnicity best describes you? ***(Check all that apply)***

☐American Indian or Alaskan Native ☐Asian ☐Native Hawaiian or Pacific Islander
☐Black or African American ☐White ☐Middle Eastern
☐Hispanic or Latino/a/x ☐Other:

What is your relationship status? ***(Check all that apply)***

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered ☐Casually dating
☐Other:

Describe your sexual practices: ***(Check all that apply)***

☐NOT sexually active / abstinent ☐Asexual (without sexual feelings or associations)
☐Sexually active with men ☐Sexually active with women ☐Sexually active with both
☐Other:

With whom do you live? ***(Check all that apply)***

☐Alone ☐Partner ☐Parents ☐Other Family ☐Friends ☐Homeless ☐Other:

What is your education? ***(Check only one)***

☐Less than 12 years ☐High School graduate ☐College degree ☐ Postgraduate degree

What type of work are you doing? ***(Check only one)***

☐Unemployed ☐Work outside home ☐Homemaker ☐Retired ☐Disabled

4. Medical History

Please list your medical or health problems, describe when the condition was diagnosed and whether it is controlled.

Medical Problem	Year Diagnosed	Controlled?
		Yes☐ No☐
		Yes☐ No☐
		Yes☐ No☐
		Yes☐ No☐
		Yes☐ No☐
		Yes☐ No☐

5. Surgical History

Please check if you have had any of the following surgeries

Procedure		Date	Surgeon	Findings
Cystoscopy (looking inside the bladder)	☐Yes ☐No			
Laparoscopy w/removal of Endometriosis	☐Yes ☐No			
Hysterectomy (removal of uterus and cervix) Were your ovaries removed? Was the cervix retained (Supra-cervical hysterectomy)?	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No			
Myomectomy	☐Yes ☐No			
Endoscopy	☐Yes ☐No			
Colonoscopy	☐Yes ☐No			
Ovarian Cyst Removal	☐Yes ☐No			
Cesarean Delivery	☐Yes ☐No			
Appendectomy (appendix removal)	☐Yes ☐No			
Prostatectomy	☐Yes ☐No			
Colectomy (removal of colon)	☐Yes ☐No			
Vasectomy	☐Yes ☐No			
Other:				

6. Menstrual, Birth Control and Sexually Transmitted Infections History

If you DO NOT menstruate, select the reason(s) why: *(Check all that apply)*

☐Had a hysterectomy ☐Menopause ☐ Assigned MALE at birth ***then skip to***

☐On continuous menstrual suppression using birth control (e.g. Depoprovera, pills, Progesterone IUD)

☐Had an Endometrial ablation

When was your last menstrual period?

How old were you when your menstrual cycles started?

If you menstruate, do you CURRENTLY have any of the following symptoms DURING menstruation? (*Check all that apply)*

☐Heavy bleeding ☐Severe pain ☐ Irregular bleeding (more than once a month) ☐Bleeding > 7 days

☐Mood swings ☐Fatigue ☐Breast tenderness ☐Constipation ☐Diarrhea ☐Headaches

If you have painful periods, how long have you had this type of pain? Please specify years or months.

Do you CURRENTLY regularly (more than 3 times a month) miss school or work due to your painful period?

☐Yes ☐No

If you have painful periods, have you used any of the following to help with your pain during your period? *(Check all that apply)*

☐ Birth Control Pill ☐ Vaginal ring ☐ Depo Provera ☐ Hormonal IUD

☐NSAIDS (e.g. Ibuprofen, Naproxen) ☐Acetaminophen ☐Other:

What are you using for birth control / contraception? *(Check all that apply)*

☐ Nothing ☐ Vasectomy ☐Condoms ☐ Birth control pills ☐ Depoprovera injection

☐ Nexplanon implant ☐ Vaginal ring (NuvaRing) ☐Tubal Ligation

☐ Hormonal IUD ☐ Non-Hormonal IUD Other:

Have you ever had any sexually transmitted infections (STIs)? *(Check all that apply)*

☐Chlamydia ☐Gonorrhea ☐Herpes ☐HPV (Human Papilloma Virus) ☐Syphilis

☐PID (Pelvic Inflammatory Disease) ☐HIV ☐Hepatitis B ☐Hepatitis C

7. Allergies and Current Medications

Please list your allergies:

Allergy	Reaction, what happens when you have this allergy?	Have you had treatments in the past for this allergy?

Please list all CURRENT medications you are taking, including herbal remedies:

Medication or Herbal Remedies	Dose	For what medical condition

8. Pregnancy / Obstetric History

How many pregnancies have you had? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many deliveries have you had? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many deliveries were vaginal? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many deliveries were cesarean? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

How many were miscarriages or abortions? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

Where there any complications during pregnancy, labor, delivery, or postpartum?

☐ Laceration 3°- 4° ☐Vacuum/ Forceps ☐Wound complication ☐Other

9. Family History

Has anyone in your family had any of the following condition(s)? *(Check all that apply)*

☐Endometriosis ☐Fibromyalgia ☐Chronic pelvic pain ☐Irritable bowel syndrome ☐ Interstitial Cystitis

☐Colon Cancer ☐Breast Cancer ☐Uterine Cancer ☐Ovarian Cancer ☐Depression

☐Chronic Fatigue Syndrome ☐ Anxiety/Panic Attacks ☐Temporomandibular Joint Disorder (TMD)

☐Migraine Headache ☐Post-Traumatic Stress Disorder (PTSD)

☐Other Chronic Condition:

10. Pain History, Description and Contributing Factors

When did your pain begin? Month: Year: ☐Unsure

Please use your own words to describe your pain:

How did your main pain begin, do you recall a specific incident that occurred when your pain first began? *(Check one)*

☐Injury at home ☐Injury at work/school ☐Injury in other setting ☐Motor vehicle crash
☐After surgery ☐Cancer ☐Medical condition other than cancer
☐No obvious cause/ do not know a specific incident ☐Other:

How did your pain begin? *(Check only one)* ☐Suddenly ☐Gradually

How long has your main pain been present? *(Check only one)*

☐Less than 3 months ☐3-12 months ☐12 months-2 years ☐2-5 years ☐More than 5 years

Since your pain began, is your pain: *(Check only one)*

☐No different ☐Getting better ☐Getting worse ☐I don't know

Which statement best describes your pain? *(Check only one)*

☐Always present (always the same intensity)
☐Always present (level of pain varies)
☐Often present (pain free periods less than 6 hours)
☐Occasionally present (once to several times per day lasting up to an hour)
☐Rarely present (pain occurs every few days or weeks)

How would you describe your pain: (*Check all that apply)*

☐Sharp, stabbing ☐Crampy ☐Heavy feeling in the pelvis ☐Dull, achy pain
☐Pulling, tugging pain ☐Throbbing pain ☐Burning pain ☐Falling out sensation
☐Other:

Does your pain ever wake you up from your sleep? ☐Yes ☐No

Does your pain ever radiate or spread to other regions of your body? ☐Yes ☐No

What makes your pain WORSE? *(Check all that apply)*

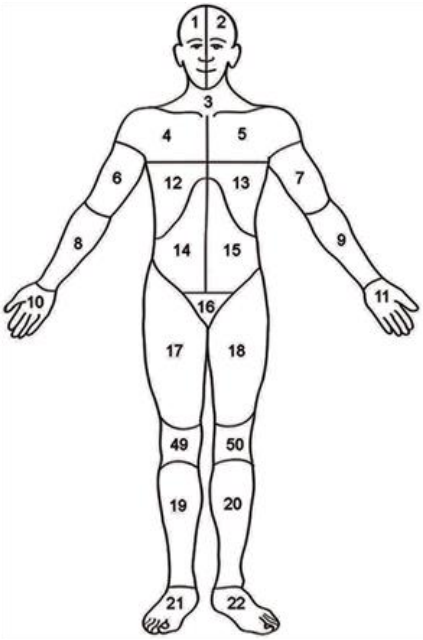
☐Walking ☐Climbing stairs ☐Urination ☐Heavy lifting ☐**Nothing makes it worse**
☐Full bladder ☐Stress ☐Housework ☐The weather ☐Getting in/out of the car
☐Exercise ☐Menstrual period ☐Contact with clothing ☐Intercourse/ Sexual contact
☐Bowel movements ☐Other:

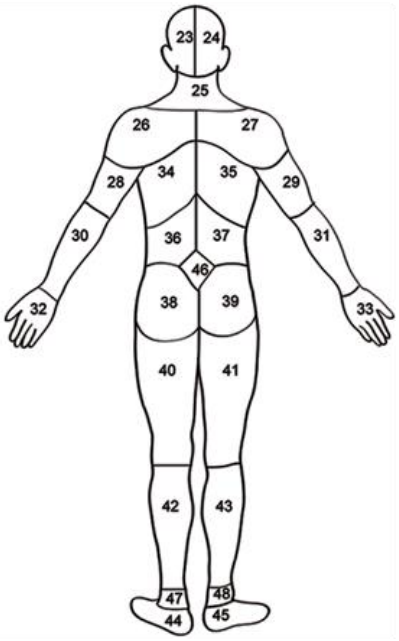
What makes your pain BETTER? *(Check all that apply)*

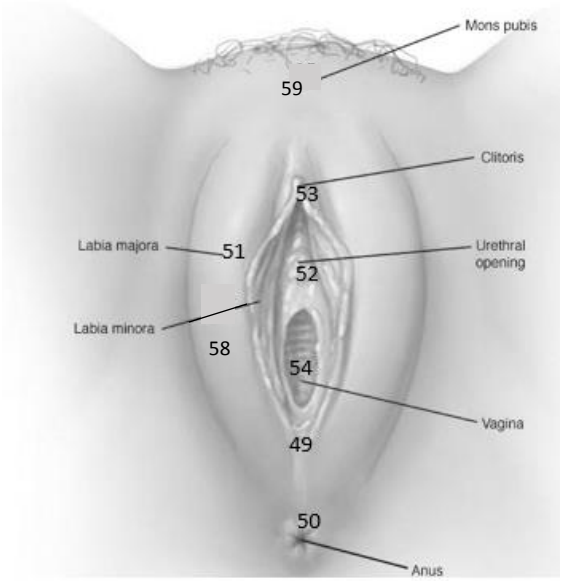
☐Lying down/rest ☐Emptying bladder ☐ Ice or Heating pad ☐**Nothing makes it better**
☐Meditation ☐Laxatives/enema ☐It goes away by itself ☐When I feel supported
☐Hot bath ☐Massage ☐Bowel movements ☐When my stress is low
☐Exercise ☐Ibuprofen or Tylenol ☐Prescription pain medications
☐Being distracted, when I am busy doing other things ☐Other:

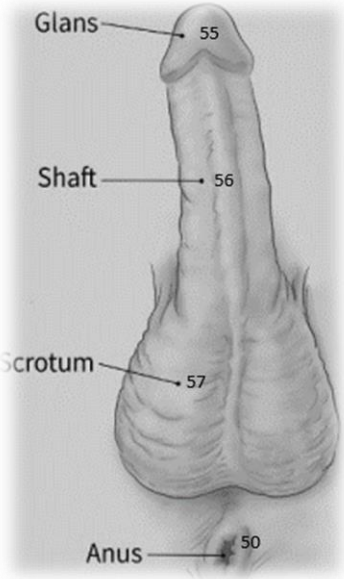
11. Pain Location, Severity Scales and Past Treatments

Please mark ALL areas where you have pain on the Body Maps below as they apply to you. Please shade or circle each area of pain.









Short McGill Questionnaire

List each ***pain location number from the body map in the first column***. **Then, select the length, quality and severity of pain at each location. [IF YOU HAVE MORE THAN 3 AREAS OF PAIN, FILL THIS FOR YOUR 3 WORSE AREAS]**			
Example			
(if 1 is by your pelvis it means the pain is in your pelvis) **1**	☐1 year ☒**1-3 years** ☐4-7 years ☐8-10 years ☐More than 10 years	☒**Throbbing** ☐Shooting ☐Stabbing ☐Sharp ☐Cramping ☐Gnawing ☐Hot-Burning ☒**Aching** ☐Heavy ☐Tender ☐Splitting ☐Tiring-Exhausting ☐Sickening ☐Fearful ☐Punishing-Cruel	☐Mild ☐Moderate ☒**Severe**
This means you've had severe throbbing, aching, pelvic pain for 1-3 yeas.			
Location Number:	☐1 year ☐1-3 years ☐4-7 years ☐8-10 years ☐More than 10 years	☐Throbbing ☐Shooting ☐Stabbing ☐Sharp ☐Cramping ☐Gnawing ☐Hot-Burning ☐Aching ☐Heavy ☐Tender ☐Splitting ☐Tiring-Exhausting ☐Sickening ☐Fearful ☐Punishing-Cruel	☐Mild ☐Moderate ☐Severe
Location Number:	☐1 year ☐1-3 years ☐4-7 years ☐8-10 years ☐More than 10 years	☐Throbbing ☐Shooting ☐Stabbing ☐Sharp ☐Cramping ☐Gnawing ☐Hot-Burning ☐Aching ☐Heavy ☐Tender ☐Splitting ☐Tiring-Exhausting ☐Sickening ☐Fearful ☐Punishing-Cruel	☐Mild ☐Moderate ☐Severe
Location Number:	☐1 year ☐1-3 years ☐4-7 years ☐8-10 years ☐More than 10 years	Throbbing ☐Shooting ☐Stabbing ☐Sharp ☐Cramping ☐Gnawing ☐Hot-Burning ☐Aching ☐Heavy ☐Tender ☐Splitting ☐Tiring-Exhausting ☐Sickening ☐Fearful ☐Punishing-Cruel	☐Mild ☐Moderate ☐Severe

Indicate on this line by checking a box to describe how bad your <u>MAIN</u> pain is:

☐0	☐ 1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

No Pain **Worse imaginable pain**

Rate the SEVERITY OF YOUR PAIN (*YOUR WORSE OR MAIN PAINFUL AREA*) on the scales below:

In the past ***7 days***….

	Had no pain	Mild	Moderate	Severe	Very severe
1. How intense was your pain at its worse?	☐1	☐2	☐3	☐4	☐5
2. How intense was your average pain?	☐1	☐2	☐3	☐4	☐5
3. What is your level of pain right now?	☐1	☐2	☐3	☐4	☐5

Mark the one box that describes how much, during the past week, pain has interfered with:

	0= does NOT interfere										**completely interferes=10**
General activity	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Mood	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Walking activity	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Normal activity (outside the home or with housework)	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Relations with other people	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Sleep	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Enjoyment of life	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Please read each statement and circle a number 0,1,2,3, or 4 which indicates how much the statement applies to you when you are experiencing pain.

PCS

When I am in pain…	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end.	☐0	☐1	☐2	☐3	☐4
I feel I can't go on	☐0	☐1	☐2	☐3	☐4
It's terrible and I think it's never going to get any better	☐0	☐1	☐2	☐3	☐4
It's awful and I feel it overwhelms me	☐0	☐1	☐2	☐3	☐4
I feel I can't stand it anymore	☐0	☐1	☐2	☐3	☐4
I become afraid that the pain will get worse	☐0	☐1	☐2	☐3	☐4
I keep thinking of other painful events	☐0	☐1	☐2	☐3	☐4
I anxiously want the pain to go away	☐0	☐1	☐2	☐3	☐4
I can't seem to keep it out of my mind	☐0	☐1	☐2	☐3	☐4
I keep thinking about how much it hurts	☐0	☐1	☐2	☐3	☐4
I keep thinking about how badly I want the pain to stop	☐0	☐1	☐2	☐3	☐4
There's nothing I can do to reduce the intensity of the pain	☐0	☐1	☐2	☐3	☐4
I wonder whether something serious may happen	☐0	☐1	☐2	☐3	☐4

If assigned FEMALE at birth, complete this questionnaire to assess the impact of your pain on your sexuality.

Interest in Sexual activity in the PAST 30 DAYS						
1. How interested have you been in sexual activity?	Not at all ☐1	A little bit ☐2	Somewhat ☐3	Quite a bit ☐4	Very ☐5	
2. How often have you felt like you wanted to have sex?	Never ☐1	Rarely ☐2	Sometimes ☐3	Often ☐4	Always ☐5	
Lubrication over the PAST 4 WEEKS…						
3. How often did you become lubricated 'wet' during sexual activity or intercourse?	No sexual activity ☐0	Almost always or always ☐5	Most times (more than half the time) ☐4	Sometimes (about half the time) ☐3	A few times (less than half of the time) ☐2	Almost never or ever ☐1
In the past 30 days…						
4. How difficult has it been for your vagina to be lubricated or 'wet' when you wanted it to?	Not at all ☐1	A little bit ☐2	Somewhat ☐3	Quite a bit ☐4	Very ☐5	
Vaginal Discomfort in the PAST 30 DAYS…						
5. How would you describe the comfort of your vagina during sexual activity?	Have not had any sexual activity in the past 30 days ☐0	Never ☐1	Rarely ☐2	Sometimes ☐3	Often ☐4	Always ☐5
6. How often have you had difficulty with sexual activity because of discomfort or pain in your vagina?	Have not had any sexual activity in the past 30 days ☐0	Never ☐1	Rarely ☐2	Sometimes ☐3	Often ☐4	Always ☐5
7. How often have you stopped sexual activity because of discomfort or pain in your vagina?	Have not had any sexual activity in the past 30 days ☐0	Never ☐1	Rarely ☐2	Sometimes ☐3	Often ☐4	Always ☐5
Orgasm in the PAST 30 DAYS...						
8. How would you rate your ability to have a satisfying orgasm/climax?	Have not tried to have an orgasm/climax in the past 30 days ☐0	Excellent ☐5	Very good ☐4	Good ☐3	Fair ☐2	Poor ☐1
Satisfaction in the PAST 30 DAYS…						
9. When you have had sexual activity how much have you enjoyed it?	Have not had any sexual activity in the past 30 days ☐0	Not at all ☐1	A little bit ☐2	Somewhat ☐3	Quite a bit ☐4	Very ☐5
10. When you have had sexual activity, how satisfying has it been?	Have not had any sexual activity in the past 30 days □0	Not at all □1	A little bit □2	Somewhat □3	Quite a bit □4	Very □5

PROMIS Sexual Function Profile v1.0-Female

If assigned MALE at birth, complete this questionnaire to assess the impact of your pain on your sexuality.

Interest in Sexual activity in the PAST 30 DAYS						
How interested have you been in sexual activity?	Not at all ☐1	A little bit ☐2	Somewhat ☐3	Quite a bit ☐4	Very ☐5	
How often have you felt like you wanted to have sex?	Never ☐1	Rarely ☐2	Sometimes ☐3	Often ☐4	Always ☐5	
Erectile function, in the PAST 30 DAYS						
In the past 30 days…						
How difficult has it been for you to get an erection when you wanted to? (If you use pills, injections, or a penis pump to help you get an erection, please answer this question thinking about the times that you used these aids)	Have not tried to get an erection in the past 30 days ☐0	Not at all ☐5	A little bit ☐4	Somewhat ☐3	Quite a bit ☐2	Very ☐1
In the PAST 30 DAYS…						
How difficult has it been to keep an erection (stay hard) when you wanted to? (If you use pills, injections, or a penis pump to help you get an erection, please answer this question thinking about the times that you used these aids)	Have not had erection in the past 30 days ☐0	Not at all ☐5	A little bit ☐4	Somewhat ☐3	Quite a bit ☐2	Very ☐1
How would you rate the following in the LAST 4 WEEKS						
Your ability to have an erection		Very poor ☐1	Poor ☐2	Fair ☐3	Good ☐4	Very good ☐5
Orgasm in the PAST 30 DAYS...						
How would you rate your ability to have a satisfying orgasm/climax?	Have not tried to have an orgasm/climax in the past 30 days ☐0	Excellent ☐5	Very good ☐4	Good ☐3	Fair ☐2	Poor ☐1
Satisfaction in the PAST 30 DAYS…						
When you have had sexual activity how much have you enjoyed it?	Have not had any sexual activity in the past 30 days ☐0	Not at all ☐1	A little bit ☐2	Somewhat ☐3	Quite a bit ☐4	Very ☐5
When you have had sexual activity, how satisfying has it been?	Have not had any sexual activity in the past 30 days □0	Not at all □1	A little bit □2	Somewhat □3	Quite a bit □4	Very □5

PROMIS Sexual Function Profile v1.0-Male

REGARDLESS OF YOUR GENDER, please respond to each question or statement ABOUT YOUR GENERAL HEALTH by marking 1 box per row.

In general, would you say your health is?	Excellent □5	Very good □4	Good □3	Fair □2	Poor □1
In general, would you say your quality of life is?	Excellent □5	Very good □4	Good □3	Fair □2	Poor □1
In general, how would you rate your physical health?	Excellent □5	Very good □4	Good □3	Fair □2	Poor □1
In general, how would you rate your mental health, including mood and your ability to think?	Excellent □5	Very good □4	Good □3	Fair □2	Poor □1
In general, how would you rate your satisfaction with your social activities and relationships?	Excellent □5	Very good □4	Good □3	Fair □2	Poor □1
In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	Excellent □5	Very good □4	Good □3	Fair □2	Poor □1
To what extend are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair	Completely □5	Mostly □4	Moderately □3	A little □2	Not at all □1
In the past 7 days…					
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never □1	Rarely □2	Sometimes □3	Often □4	Always □5
How would you rate your fatigue on average?	None □1	Mild □2	Moderate □3	Severe 4□	Very severe □5
How would you rate your pain on average?	□ 0-no pain	□ 1	□ 2	□ 3	□ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Worst imaginable pain

[For health care providers-PROMIS scoring methods http://www.healthmeasures.net/score-and-interpret/calculate-scores]

PROMIS Global Health v.1.1

What medications have you tried in the PAST for your pelvic pain? *(Check all that apply)*

Medication	Currently on Medication	Have tried this medication in the past	Did you find this medication helpful?
Gabapentin (Neurontin®)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Pregabalin (Lyrica®)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Amitriptyline (Elavil®)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Duloxetine (Cymbalta®)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Milnacipran (Savella®)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Trazodone	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Oral Muscle relaxer	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Diazepam Suppository (Valium®)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Opioids	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐ Somewhat☐
Other Medication not listed:			

What OTHER TREATMENTS have you tried for your pelvic pain IN THE PAST? *(Check all that apply)*

☐Acupuncture ☐Massage ☐Nutrition/Diet ☐Physical Therapy ☐Biofeedback
☐Trigger Point Injections ☐TENS Unit ☐Botox Injections ☐Nerve Blocks
☐Epidural ☐Sex therapy ☐Joint Injections ☐Neurostimulation
☐Bladder instillations ☐Aqua therapy ☐Cognitive Behavioral Therapy
☐Radio Frequency Ablation (RFA) ☐NONE
☐Hormonal treatment-- if yes, what type of hormonal treatment? (***Check all that apply)***
☐Pills ☐Patch ☐Ring ☐ Injections ☐Estrogen ☐Progesterone
Other treatments:

12. Gastrointestinal History

Do you have any of the following GASTROINTESTINAL (BOWEL) symptoms? *(Check all that apply)*

Nausea/vomiting? ☐Yes ☐No
Diarrhea: ☐Yes ☐No
Abdominal pain: ☐Yes ☐No
Bloating: ☐Yes ☐No
Constipation: ☐Yes ☐No
Reflux / Heartburn: ☐Yes ☐No

Do you have increased pain with bowel movements? ☐Yes ☐No

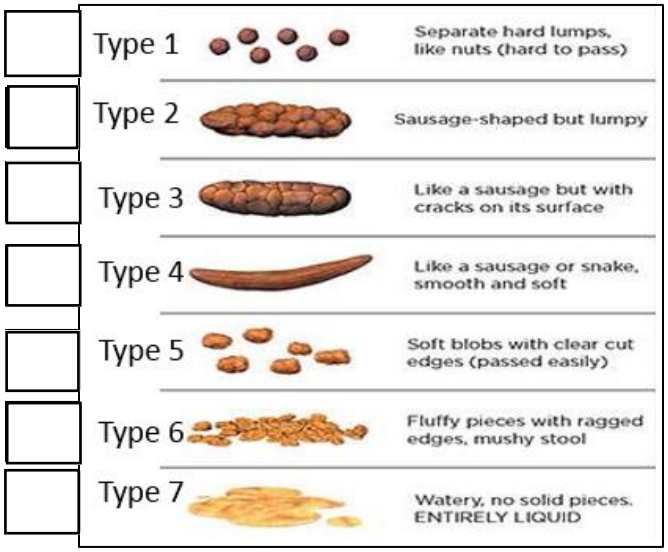
Do you have any rectal bleeding or blood in your stool? ☐Yes ☐No

Have you ever seen a gastroenterologist (GI specialist)? ☐Yes ☐No

Do you have pain or discomfort that is associated with any of the following?
Change in frequency of bowel movement? ☐Yes ☐No
Change in appearance of stool or bowel movement? ☐Yes ☐No

Does your pain improve or get worse around times of having a bowel movement? ☐Yes ☐No

What do your stools look like MOST of the time? ***Select one type from the chart***



13. Additional Symptoms and Diagnoses

Do you have pain in your vulva/labia, clitoris, scrotum, penis or anus?	☐Yes	☐No
Do you have numbness in the same area?	☐Yes	☐No
Is your pain worsened by sitting?	☐Yes	☐No
Does the pain wake you up at night?	☐Yes	☐No
Have you ever had a pudendal nerve block?	☐Yes	☐No
If yes, did you have improvement in pain (even if temporary)?	☐Yes	☐No
Have you ever had any severe sport injuries (e.g. injuries during running, lifting, gymnastics)?	☐Yes	☐No
Have you ever had any motor vehicle accident injuries to your head, neck, spine or back?	☐Yes	☐No
Have you ever had any fall injuries (e.g. injuries to your back, tailbone, neck)?	☐Yes	☐No

Have you ever been diagnosed, or treated for any of these conditions? ***(Check all that apply)***

Condition		
Fibroids	☐Yes	☐No
Endometriosis	☐Yes	☐No
Fibromyalgia	☐Yes	☐No
Chronic fatigue syndrome / Myeloencephalitis	☐Yes	☐No
Interstitial cystitis / Bladder pain syndrome	☐Yes	☐No
Chronic low back pain	☐Yes	☐No
Chronic headaches or migraines	☐Yes	☐No
TMJ (Temporomandibular joint disorder)	☐Yes	☐No
Abnormal pap smear	☐Yes	☐No
Breast cancer	☐Yes	☐No
Other:		

14. Urinary History

Do you experience any of the following URINARY SYMPTOMS? *(Check all that apply)*

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 urinate again within minutes of urinating?	☐Yes	☐No
Urgency to go urinate	☐Yes	☐No

If assigned FEMALE at birth, complete the bladder function and symptom questionnaire. Please respond to questions 4-6 ONLY IF you engage in sexual intercourse.

Pelvic Pain / Urinary Frequency Questionnaire	0	1	2	3	4
1. How many times do you go to the bathroom **DURINGTHE 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 ☐	

If assigned MALE at birth, please complete the Chronic Prostatitis Symptom Index (NIH):

1.In the last week, have you experienced any pain or discomfort in the following areas?	
a. Area between rectum and testicles (perineum)	☐1 Yes ☐2 No
b. Testicles	☐1 Yes ☐2 No
c. Tip of penis (not related to urination)	☐1 Yes ☐2 No
d. Below your waist, in your pubic or bladder area	☐1 Yes ☐2 No
2.In the last week, have you experienced:	
a. Pain or burning during urination?	☐1 Yes ☐2 No
b. Pain or discomfort during or after sexual climax (ejaculation)?	☐1 Yes ☐2 No
3.How often have you had pain or discomfort in any of these areas (a-d) over the last week?	☐0 Never ☐1 Rarely ☐2 Sometimes ☐3 Often ☐4 Usually ☐5 Always
4.Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?	**No Pain** **Worse imaginable pain** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
5.How often have you had the sensation of not emptying your bladder completely after you finished urinating, over the last week?	☐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 ☐5 Almost always
6.How often have you had to urinate again less than two hours after you finished urinating, over the last week	☐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 ☐5 Almost always
7.How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?	☐0 None ☐1 Only a little ☐2 Some ☐3 A lot
8.How much did you think about your symptoms over the last week?	☐0 None ☐1 Only a little ☐2 Some ☐3 A lot
8.If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?	☐0 Delighted ☐1 Pleased ☐2 Mostly satisfied ☐3 Mixed (equally satisfied and dissatisfied ☐4 Mostly dissatisfied ☐5 Unhappy ☐6 Terrible
Scoring	
Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3 and 4 =	
Urinary symptoms: Total of times 5 and 6 =	
Quality of life impact: Total of times 7, 8 and 9 =	

1. Psychosocial History

What is the main source of stress in your life? ☐ Work ☐Family ☐Financial ☐Social ☐Relationships

Who are the people you talk to concerning your pain, during stressful times?

☐Spouse/ Partner ☐Relative ☐Support Group ☐Clergy ☐Doctor/Nurse
☐Friend ☐Mental Health Provider ☐I take care of myself

Have you ever experienced abuse or trauma as a child (13 years or younger)? (***Check all that apply***)

☐Emotional ☐Physical ☐Sexual ☐ Domestic Violence

Have you ever experienced abuse as an adult?

☐Emotional ☐Physical ☐Sexual ☐ Domestic Violence

Are you currently experiencing abuse?

☐Emotional ☐Physical ☐Sexual ☐ Domestic Violence

Have you ever received mental health treatment?

☐Medications ☐Therapy ☐Hospitalization

Are you currently still receiving mental health treatment? ☐Yes ☐No

If yes, please explain:

Do you have a history of?

☐Depression ☐ Anxiety ☐Panic Attacks ☐Bipolar Disorder
☐Trauma ☐PTSD ☐Disordered eating ☐None of these

Compared to other stressors in your life, how does your pain compare in importance?

☐ Most important ☐One of many problems

Are there relationships you think that may be contributing to your symptoms? ☐Yes ☐No

Do those that are in your daily life understand you? ☐Yes ☐No

If you have a partner, would you characterize them as supportive? ☐Yes ☐No

Does your partner notice if you are in pain? ☐Yes ☐No

How does your partner react when you hurt? Please explain:

Do you believe that your pain impacts other areas of your life?

☐Education ☐Family ☐Recreational activities
☐Work ☐Friends ☐Sexual intimacy

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no wrong or right answers, do not spend too much time on any statement.

DASS-21	Not at all	Some of the time	A good part of the time	Most of the time
I found it hard to wind down	☐0	☐1	☐2	☐3
I was aware of dryness of my mouth	☐0	☐1	☐2	☐3
I couldn't seem to experience any positive feeling at all	☐0	☐1	☐2	☐3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	☐0	☐1	☐2	☐3
I found it difficult to work up the initiative to do things	☐0	☐1	☐2	☐3
I tended to overreact to situations	☐0	☐1	☐2	☐3
I experienced trembling (e.g. in the hands)	☐0	☐1	☐2	☐3
I felt that I was using a lot of nervous energy	☐0	☐1	☐2	☐3
I was worried about situations in which I might panic and make a fool of myself	☐0	☐1	☐2	☐3
I felt that I had nothing to look forward to	☐0	☐1	☐2	☐3
I found myself getting agitated	☐0	☐1	☐2	☐3
I found it difficult to relax	☐0	☐1	☐2	☐3
I felt down-hearted and blue	☐0	☐1	☐2	☐3
I was intolerant of anything that kept me from getting on with what I was doing	☐0	☐1	☐2	☐3
I felt I was close to panic	☐0	☐1	☐2	☐3
I was unable to become enthusiastic about anything	☐0	☐1	☐2	☐3
I felt I wasn't worth much as a person	☐0	☐1	☐2	☐3
I felt that I was rather touchy	☐0	☐1	☐2	☐3
I was aware of the action of my heart in the absence of physical exertion (e.g. a sense of heart rate increase, heart missing a beat)	☐0	☐1	☐2	☐3
I felt scared without good reason	☐0	☐1	☐2	☐3
I felt scared without good reason	☐0	☐1	☐2	☐3

Do you <u>CURRENTLY</u> use, or have you used any of the following substances in the <u>PAST 12 MONTHS</u>? *(Check <u>all</u> that apply)*

Substance			How many times a week?	Do you use this for pain control?
Do you drink any alcohol?	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Tobacco or Nicotine Products	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Cocaine / Crack	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Heroin	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Opioids	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Methamphetamines	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Stimulants	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Ecstasy	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Psychedelics	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No
Marijuana/THC/Cannabis	☐No	☐Yes	☐<1 ☐2-3 ☐>4	☐Yes ☐No

Thank you for taking the time to complete this form. This information will help your health care provider take better care of you.

For more information on chronic pelvic pain and how to prepare for your clinical evaluation, visit the 'patient resources' and 'pamphlets' section of the International Pelvic Pain Society web at www.pelvicpain.org.

FOR OFFICE USE ONLY:

Form reviewed by (Name):

Date of Review:

Health Care Provider Comments: