Overlake Reproductive Health

PELVIC PAIN HISTORY QUESTIONNAIRE

I. Personal Information

1. Race _____
2. Age _____
3. Height _____
4. Weight _____
5. Date of Birth _____
6. Marital Status _____
7. With whom do you currently live? _____
8. Number of times pregnant _____
9. Number of live births _____
10. Number of stillbirths _____
11. Number of spontaneous miscarriages _____
12. Number of ectopic pregnancies _____
13. Number of therapeutic abortions _____
14. Menstrual Status: Premenopausal _____ Postmenopausal _____
15. Last menstrual period _____
16. Interval between periods _____
17. Duration of flow _____
18. Bleeding between periods _____

II. Personal Family History

A. How often did any of your family members suffer from the following pain while you lived with them? (Circle the appropriate number of each item, 1 = never; 5 = frequently).

	Mother	Father	Siblings	Self
19. Headaches	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
20. Neck pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
21. Back pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
22. Joins pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
23. Muscle pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
24. Abdominal pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
25. Menstrual pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
26. Toothaches/Earaches	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
27. Internal pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
28. Physical illnesses (colds, etc)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
29. Other pains	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

30. Describe: _____

III. Job History

31. Are you currently: (check one)

_____ employed _____ unemployed _____ housewife _____ retired

_____ disabled _____ student _____ other

32. In the past year have you worked: (check one)

_____ Full-time _____ Part-time

_____ Irregularly _____ Not at all

33. If you are a student, are you: (check one)

_____ Full-time undergraduate

_____ Part-time undergraduate

_____ Full-time graduate student

_____ Part-time graduate student

_____ High school student

34. If you are not a student, please answer the following question.

List occupation(s): _____

35. List partner or spouse's occupation(s): _____

36. Have you had a recent job injury that caused you to miss work? _____ yes _____ no

37. Have you had a recent non-job related injury that caused you to miss work?

_____ yes _____ no

38. Are you currently in litigation involving an injury? _____ yes _____ no

39. Are you currently receiving disability payments for any injury? _____ yes _____ no

IV. Medical History

A. Medical Problems: (Have you ever been diagnosed as having significant problems with any of the following?) If yes, please specify.

40. Back, joint or bones? _____
41. Bladder, kidneys (including recurrent infections)? _____
42. Intestinal system (including stomach, bowel, liver)? _____
43. Heart or blood vessels? _____
44. Lungs? _____
45. Brain, headaches, seizures, etc.? _____
46. Psychological problems? _____
47. Pain other than pelvic? _____

B. Past History and Treatment - Have you had any of the following?

	# of times	Date	Findings
48. Hysterectomy (abdominal/vaginal)	_____	_____	_____
49. Salpingo-oophorectomy-right (tubes or ovaries removed)	_____	_____	_____
50. Salpingo-oophorectomy-left	_____	_____	_____
51. Salpingo-oophorectomy-both	_____	_____	_____
52. Appendectomy or intestinal surgery	_____	_____	_____
53. Cesarean Section	_____	_____	_____
54. Laparotomy	_____	_____	_____
55. Laparoscopy	_____	_____	_____
56. D & C	_____	_____	_____
57. Lysis of Adhesions	_____	_____	_____
58. Ovarian cyst removed	_____	_____	_____

59. Surgery to remove endometriosis _____ _____ _____
60. Tubal Ligation _____ _____ _____
61. Tubal-Ovarian Abscess Drainage _____ _____ _____
62. Tubal-Ovarian Abscess Removal _____ _____ _____
63. Cone Biopsy, cryotherapy or loop to cervix _____ _____ _____
64. Surgery on Fallopian tube(s) _____ _____ _____
65. Urinary or bladder surgery _____ _____ _____
66. Removal of cautery or laser of nerves supplying the pelvic organs _____ _____ _____
67. Bowel resection _____ _____ _____
68. Other exploratory abdominal surgery _____ _____ _____

C. Gynecologic History

69. Pelvic inflammatory disease (infection in ovaries, tubes or uterus) _____ _____ _____
70. Endometriosis _____ _____ _____
71. Ovarian cyst/tumor _____ _____ _____
72. Inability to get pregnant _____ _____ _____
73. Fibroids of the uterus _____ _____ _____
74. Scar tissue in female organs _____ _____ _____
75. Uterine prolapse (uterus falling out) or other organs falling out (bladder, rectum) _____ _____ _____
76. Gonorrhea _____ _____ _____
77. Chlamydia _____ _____ _____
78. Herpes _____ _____ _____
79. Human papilloma virus or condyloma (warts) _____ _____ _____
80. Have you ever had:
    1. Urethal dilation? _____
    2. Recurrent bladder infection? _____
    3. Urinary incontinence? _____
    4. Urologic or bladder surgery? _____
    5. Cystoscopy? _____

    Findings: _____

81. Dysmenorrhea (painful menstruation)
    0 None _____
    1 Now _____
    2 Before _____
    3 Both _____
82. Menorrhagia (excessive bleeding)
    0 None _____
    1 Now _____
    2 Before _____
    3 Both _____
83. Prolonged Bleeding
    0 None _____
    1 Now _____
    2 Before _____
    3 Both _____

84. Irregular Bleeding
    0 None _____
    1 Now _____
    2 Before _____
    3 Both _____
85. Infertility
    0 None _____
    1 Now _____
    2 Before _____
    3 Both _____

D. Contraception

86. Are you or your partner using any contraceptive measures (to prevent pregnancy)?
    _____ yes _____ no
    What method? _____
87. Have you had an IUD? _____ yes _____ no

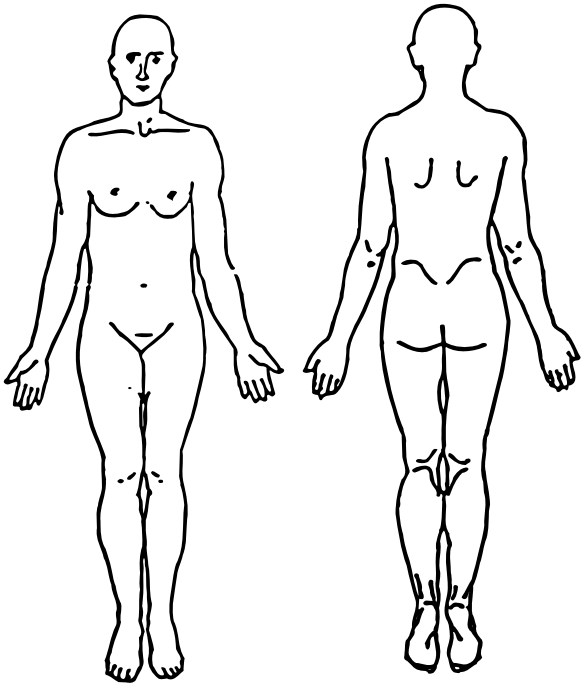
E. Sexual History

88. Age of first intercourse _____
    I choose not to answer this _____
89. Total number of sexual partners _____
    I choose not to answer this _____
90. Have you ever experienced a sexual trauma other than rape? (abuse, incest, molestation)
    _____ yes _____ no
    I cannot talk about this _____
    I choose not to answer this question _____
    If you answered “yes”, would you briefly describe this trauma(s) and would you briefly describe any counseling or therapy you had for this trauma: _____
    _____
    _____
91. Have you ever been raped? _____ yes _____ no
    I cannot talk about this _____
    I choose not to answer this question _____
    If you answered “yes”, would you briefly describe this trauma(s) and would you briefly describe any counseling or therapy you had for this trauma: _____
    _____
    _____
92. Do you have pain with sexual intercourse? _____ yes _____ no
93. Where is the pain located?
    1. Opening of vagina _____
    2. Deep within the vagina _____
    3. Lower abdomen _____
94. How much does the pain interfere with your desire for or enjoyment of sexual activity? (1 = no interference, 10 = unable to have sexual activity because of pain) _____
95. Are you still engaging in intercourse _____ yes _____ no
96. Is it difficult to become aroused? _____ yes _____ no
97. Do you lubricate well? _____ yes _____ no
98. Are you able to achieve orgasm? _____ yes _____ no
99. Do you think your partner is satisfied? _____ yes _____ no

V. Pain History

100. Where is your pain?

On the diagrams below, shade in or place x's in those areas where you feel pain. Put "E" if external, or "I" if internal, near the areas which you mark. Put "EI" if both external and internal. Also: if you have one or more areas which can trigger your pain when pressure is applied to them, mark each with an "x".



Comments: _____

_____

_____

_____

101. Is your pain only during your periods? _____ yes _____ no

102. Does your pain occur with any specific relationship to your menstrual cycle?

_____ yes _____ no

If yes, describe _____

103. What makes your pain worse? _____

104. How can you lessen your pain? _____

105. Are there times during which you experience no pain at all? _____ yes _____ no

If yes, how long do these pain-free intervals last? _____ hours _____ minutes

106. Is your pain present:

a. No pain _____

b. Through the day _____

c. Part of every day (specify) _____

d. Part of every week (specify) _____

e. Occasionally, each month, or less than that (specify) _____

_____

f. At night _____ yes _____ no

g. At night and does it interrupt sleep? _____ yes _____ no

If yes, please specify when pain is worse.

_____ night _____ afternoon _____ morning _____ evening

107. The pain is brought on by:

a. touching the skin surface _____ yes ____ no
b. physical exercise _____ yes ____ no
c. eating _____ yes ____ no
d. coughing _____ yes ____ no
e. bending over _____ yes ____ no
f. full bladder _____ yes ____ no
g. urinating _____ yes ____ no
h. full bowel _____ yes ____ no
i. sexual intercourse _____ no _____ during _____ after _____ during and after
j. movement of a body part _____ yes ____ no
k. position of a body part _____ yes ____ no
l. standing _____ yes ____ no
m. sitting _____ yes ____ no
n. lying down _____ yes ____ no
o. bowel movement _____ yes ____ no
p. constipation _____ yes ____ no
q. menses _____ yes ____ no

E. <u>Other Characteristics - Urinary Tract</u>

108. Do you have pain with urination? _____ yes ____ no
109. Do you feel the urge to urinate frequently? _____ yes ____ no
110. Do you always have an uncomfortably strong need to pass urine before you empty your bladder? _____ yes ____ no
111. Do you lose urine before reaching the toilet? _____ yes ____ no
If yes, is this urine painful? _____ yes ____ no
112. Do you have to hurry to the toilet or can you take your time? _____ yes ____ no
113. Can you overcome the uncomfortable strong need to pass urine?
Please check: _____ usually _____ occasionally _____ rarely
114. Do you have any uncomfortably strong need to pass urine with a full bladder? _____ yes ____ no
115. Without a full bladder? _____ yes ____ no
116. Have you had treatment for urinary tract disease such as:
_____ stones _____ kidney disease _____ infections
_____ tumors _____ injuries
117. Have you ever had:
_____ paralysis _____ polio _____ multiple sclerosis _____ strokes _____ back pain
_____ syphilis _____ diabetes _____ pernisious anemia
118. Have you had an operation on your: _____ spine _____ brain _____ bladder
119. Have you had a bladder infection during the last year _____, or more than twice during the year _____?
120. Did your bladder infection follow intercourse at any time _____?
If yes, at what age did you stop _____?
121. Do you wet the bed now _____?
122. What is volume of urine you usually pass: _____ large _____ medium _____ small
123. Do you notice any dribbling of urine when you stand after passing urine _____?
124. Do you lose urine when you: _____ cough _____ sneeze _____ vomit
If yes, in which position does it occur: _____ standing _____ sitting _____ lying down

125. Do you lose urine without vomiting, sneezing or coughing _____?
If yes, when does it occur? _____ walking _____ lying down _____ running _____ straining _____ after intercourse _____ during intercourse _____ any change position
126. Did your urine difficulty start during: _____ pregnancy _____ after delivery
127. Did it follow an: _____ operation _____ hysterectomy _____ through the vagina _____ removal of a tumor through the abdomen _____ vaginal repair operation _____ suspension of the uterus or bladder _____ cesarean section _____ other
128. If your menstrual periods have stopped, did the menopause make your condition worse? _____
129. Do you find it necessary to wear protection because you get wet from the urine you lose? _____
130. When do you wear protection? _____ occasionally _____ all the time _____ during the day _____ at night
131. When you lose urine accidentally, are you unaware that it is passing? _____
132. How many times do you void during the night after going to bed? _____
133. Does the strong need to pass urine wake you up? _____
134. How much fluid do you usually drink before going to bed? _____ cups
135. Do you have pain while passing urine? _____
136. How often do you pass urine during the day? _____
137. Is it necessary for you to pass urine frequently? _____
138. Does the sound, sight or feel of running water cause you to lose urine? _____
139. Are you ever suddenly aware that you are losing or are about to lose urine? _____
How often does this occur? _____ day _____ night
140. Do you usually have difficulty starting your urine stream? _____
How long has this problem occurred? _____
141. Do you find it frequently necessary to have your urine removed by means of a catheter because you are unable to pass it? _____
142. In the space below, please summarize your urine problem as briefly as possible: _____

_____

_____

_____

_____

_____

_____

F. <u>Gastrointestinal</u>

143. Do you have pain with bowel movements?	_____ yes	_____ no
144. Is this pain often made better by having a bowel movement?	_____ yes	_____ no
145. Do you often have more bowel movements (stools) when this pain begins?	_____ yes	_____ no
146. Do you often have looser bowel movements when this pain begins?	_____ yes	_____ no
147. After finishing a bowel movement, do you often feel there is still stool that needs to be passed?	_____ yes	_____ no
148. Have you seen blood or mucus in your stools in the last year?	_____ yes	_____ no
149. Do you often feel bloated and actually see your belly swell?	_____ yes	_____ no
150. Do you have constipation or diarrhea?	_____ yes	_____ no

Which? _____

151. Which of the following statements best characterizes your pain/discomfort?

_____ Periods when I feel almost normal/asymptomatic alternate with periods when I feel a lot of discomfort.

_____ Pain and discomfort are constant, present 24 hours a day and not affected by anything I do, including food intake or medications.

_____ Pain and discomfort are constant, but they are made worse by eating or stress.

_____ Pain and discomfort come and go periodically (i.e., periods of at least a month with no pain, with periods in between of weeks to months when there is pain).

152. Does your ache, pain or discomfort often (more than 25% of the time) occur before meals or when hungry? _____ yes _____ no

153. Does your ache, pain or discomfort often occur immediately after (less than 30 minutes) meals? _____ yes _____ no

154. Does your ache, pain or discomfort often occur 30 minutes to 2 hours after meals? _____ yes _____ no

155. Is your pain or discomfort often made better (relieved) by burping (bringing up air through the mouth)? _____ yes _____ no

156. Is your pain or discomfort often made better by eating? _____ yes _____ no

157. Is your pain or discomfort often made better by taking antacids (e.g., Tums, Mylanta, Maalox, Gaviscon, Rolaids)? _____ yes _____ no

158. Is your pain or discomfort often made worse by food or drinks? _____ yes _____ no

159. If your answer between 143-158 is yes, which statement best characterizes the relationship between food intake and symptoms?

_____ only specific food items will cause symptoms

_____ Food intake in general will cause symptoms, regardless of what I eat

_____ Even drinking water makes my symptoms worse

VI. Pain Aspects

160. On a scale of 1-10 (1 = no pain, 10 = most intense pain imaginable), how would you score the usual intensity of your lower abdominal/pelvic pain?

a. _____ during periods

b. _____ not during periods

161. How bothersome or unpleasant is your pain to you? (1 = not bothersome at all, 10 = most bothersome imaginable) _____

162. How much does the pain interfere with your daily activities or daily functioning? (1 = does not interfere, 10 = interferes completely) _____

163. What effect does the pain have on your job or work at home? (check all that apply)

_____ I am unable to work at all because of pain

_____ Can work only when pain is absent

_____ Work with pain, but it is very difficult

_____ Manage to do satisfactory work in spite of pain

_____ Other _____

164. How much does the pain interfere with exercise? (1 = able to exercise, 10 = unable to exercise at all) _____

What kind of exercise do you do regularly? _____

Have you had to decrease your exercise frequency or duration? _____ yes _____ no

165. Place a slash (/) somewhere along the scale below and number it to indicate your nonmenstrual pain at (1) its greatest intensity, (2) usual intensity, and (3) lowest intensity.

No Pain ----------The most intense pain imaginable

166. Place a slash (/) somewhere along the scale below and number it to indicate your menstrual pain at (1) its greatest intensity, (2) usual intensity, and (3) lowest intensity.

No Pain ----------The most intense pain imaginable

167. What circumstances or conditions help to relieve your pain? (check all that apply)

_____pressing _____ cold packs or water _____ rubbing
_____ walking _____ drugs _____ talking
_____ lying down _____ hot packs or water _____ eating
_____ sleeping _____ other (specify) _____

168. Recent (within 3 months) changes in your pain sensation?

_____ no change _____ doesn't last as long
_____ less intense _____ concentrates on mor than one part of the body
_____ more intense _____ spread to different part of the body
_____ lasts longer _____ other changes (specify) _____

169. Have you had surgery as treatment for your current pain? If yes, what type of surgery? _____

_____
_____
_____

VII. Pain Medication

170. Drugs (medications) that you are taking for pain are: (check all that apply)

_____ Antiprostaglandin _____ Tranquilizers
_____ Narcotic _____ Sedatives - sleeping pills
_____ Narcotic w/other _____ Vitamins
_____ Acetaminophen (Tylenol) _____ Stimulants
_____ Antibiotics _____ Antidepressants
_____ Steroids (Cortisone) _____ Diuretics (waterpills)

171. How well do your medications control your pain?

_____ Pain completely goes away hen I take it
_____ Takes most of the pain away
_____ Helps pain only a little bit
_____ Has no real effect on pain
_____ Helps only for a little while
_____ Other _____

VIII. Social History

172. Do you drink alcohol? _____ yes _____ no

Please estimate type and amount used daily/weekly/monthly. _____

_____

173. Do you smoke cigarettes? _____ yes _____ no

174. Do you use any other recreational drugs (once per week or more)?

_____ yes _____ no

Type _____

Amount _____