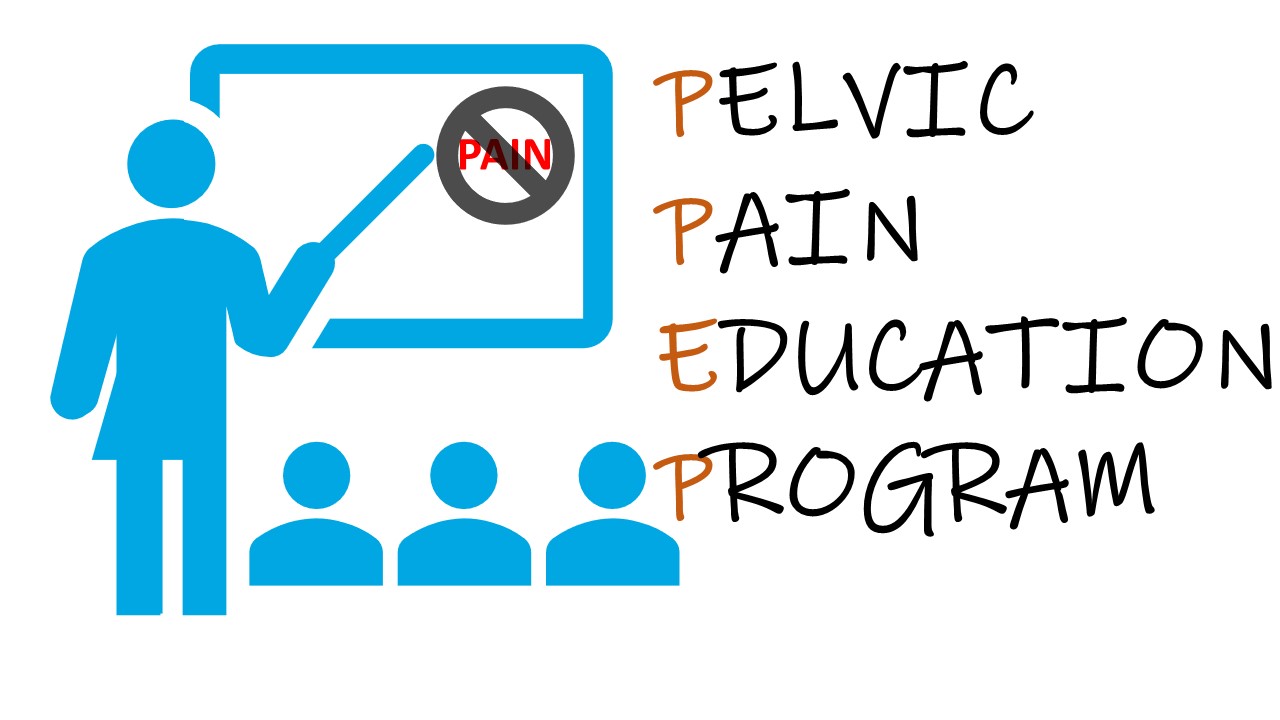
Form 002.08.26.2021

www.pelvicpaineducation.com

**INITIAL PATIENT SURVEY**

* **The information you provide on this survey is essential for making therapy recommendations.**
* **This form will take no more than 30 minutes to complete, but please take as much time as you need and answer the questions as completely as you can.**
* **When you are done, you can give this form to your clinician or a member of your healthcare team.**
* [**IMPORTANT PRIVACY AND SECURITY NOTICE:**The questionnaires below are collect private health information (PHI). DO NOT mail, fax, or email them to your clinician or to other people unless these modes of communication are equipped with encryption and security measures designed to transfer private health information.](https://b43671ae-17b3-4c94-a509-94216e51bc3f.filesusr.com/ugd/8f46f9_879c015342604627a5c69d6213091ba2.docx?dn=Health%20Care%20Professional%20INITIAL%20Assessm)



***PLEASE TELL US ABOUT YOURSELF***

**Legal Last Name:**Click or tap here to enter text. **Legal First Name:**Click or tap here to enter text.

**Date of Birth:**Click or tap to enter a date. **Age:**Click or tap here to enter text.

**Height (feet’ inches”):**Click or tap here to enter text.**Weight (pounds):**Click or tap here to enter text.

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

American Indian or Alaskan Native  Black or African American

Black or African  Black or African European

Asian  Middle Eastern

Hispanic  Latino/a/x

Native Hawaiian or Pacific Islander Other:

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

Single Married Separated Divorced Widowed Partnered

Casually dating

Other:Click or tap here to enter text.

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

Less than 12 years High School graduate College degree

Postgraduate degree  Other: Click or tap here to enter text.

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

Unemployed Employed, outside home  Self-employed at home

Retired Disabled Self-employed outside home

***PLEASE TELL US ABOUT YOUR GYNECOLOGIC HISTORY.***

1. **Do you have regular menstrual cycles?** Yes No

**5a. If you DO NOT menstruate, select the reason(s) why *(Check all that apply) and* then skip to question 9:**

Had a hysterectomy Other:Click or tap here to enter text.

Menopause

Assigned MALE at birth

On continuous menstrual suppression using birth control (for example: Birth Control pills, Depoprovera, Progesterone IUD)

Had an Endometrial ablation

**5b. If you DO menstruate, when was your last menstrual cycle?**

Date: Click or tap to enter a date. **OR** Unsure

**5c. Are your cycles regular?** Yes No Unsure

**5d. How often are your cycles?** Once a month More than once a month

**5e. How old were you when you started menstruating?**Click or tap here to enter text.Years old.

**5f. If you menstruate, do you CURRENTLY have any of the following symptoms DURING menstruation? (*Check all that apply)***

Heavy bleeding Moderate or severe pain

Irregular bleeding (more than once a month)

Bleeding > 7 days

Mood swings Fatigue Breast tenderness

Constipation Diarrhea Headaches

**5g. If you have painful periods, how long have you had this type of pain?** Please specify years or months.Click or tap here to enter text.

**5h. Do you REGULARLY (more than 2 times a month) miss school or work due to your painful period?**

Yes No

**5i. If you have painful periods, do 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:Click or tap here to enter text.

Never tried anything to manage the pain

1. **Have you ever been pregnant:** Yes No

**If you have NOT been ever been pregnant, skip to question 10.**

**7. If you have ever been pregnant:**

|  |  |
| --- | --- |
| 7.If you have been pregnant: |  |
| 7a. How many pregnancies have you had? | 0  1 2 3 4 5 6 or more |
| 7b. How many were vaginal deliveries? | 0  1 2 3 4 5 6 or more |
| 7c. How many were cesarean deliveries? | 0  1 2 3 4 5 6 or more |
| 7d. How many were miscarriages or abortions> | 0  1 2 3 4 5 6 or more |

**7f. Where there any complications during pregnancy, labor, delivery, or after the delivery?** Laceration 3°- 4° Vacuum/ Forceps

Wound complication Other

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

NEVER been sexually active ***(skip to question 12)***

NOT CURRENTLY sexually active / abstinent, but have been in the past

Sexually active with men

Sexually active with women

Sexually active with both

Asexual (without sexual feelings or associations)

Other: Click or tap here to enter text.

**8a. If you are currently sexually active, when last were you sexually active?**Click or tap to enter a date.**OR** Unsure about the date**.**

1. **Tell us about the type of contraception you are CURRENTLY using:**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| None |  |  |
| Birth Control Pills |  |  |
| Nexplanon implant |  |  |
| Tubal ligation or removal of tubes |  |  |
| Condoms |  |  |
| Vasectomy |  |  |
| Depoprovera injection |  |  |
| Vaginal ring (NuvaRing) |  |  |
| Hormonal IUD (Mirena, Skyla, Kyleena) |  |  |
| Non-hormonal IUD (ParaGard) |  |  |
| Other |  |  |

1. **Have you ever had any sexually transmitted infections (STIs)? *(Check all that apply, if you have never been sexually active you may skip this question.)***

Chlamydia Gonorrhea Herpes

HPV (Human Papilloma Virus) Syphilis

PID (Pelvic Inflammatory Disease) HIV Hepatitis B Hepatitis C

1. **When was your last pap smear?**Click or tap here to enter text. **Never had pap smear (skip to question 14)**

**12a. If you had a pap, was your last pap smear normal?** Yes No

1. **When was your last mammogram?**Click or tap here to enter text.

**13a. Was it normal?** Yes No

***PLEASE DESCRIBE YOUR MENTAL HEALTH.***

1. **What is the main source of stress in your life?** ***(Check all that apply)***

Work Family Financial Social Relationships Your health conditions

Other:Click or tap here to enter text.

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Emotional | Physical | Sexual | Domestic Violence | I have never experienced trauma |
| As a child |  |  |  |  |  |
| As an adult |  |  |  |  |  |
| Currently |  |  |  |  |  |

1. **Have you ever received mental health treatment?**

Medications Therapy Hospitalization I have not

1. **If you received mental health treatment, tell us more about your mental health history:**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| 17a. Are you currently still receiving mental health treatment? |  |  |
| 17b. Do you have a history of suicide attempts or treatment for suicidal thoughts? |  |  |
| 17c. Are there relationships you think that may be contributing to your physical or mental symptoms? |  |  |
| 17d. Do those that are in your daily life understand you |  |  |
| 17e. If you have a partner, would you characterize them as supportive? |  |  |

1. **Do you CURRENTLY use, or have you used any of the following substances in the PAST 12 MONTHS? *(Check all 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 |
| Marijuana/THC/Cannabis | No | Yes | <1 2-3 >4 | Yes No |
| Other recreational drugs | No | Yes | <1 2-3 >4 | Yes No |

***PLEASE DESCRIBE YOUR MEDICAL AND FAMILY HISTORY.***

1. **Please tell us if YOU or any of your CLOSE RELATIVES (parents, siblings, grandparents) have *ever* been diagnosed with any of these conditions (Check *all* that apply):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | You | Parents | Siblings | Grandparents |
| Fibroids |  |  |  |  |
| Endometriosis |  |  |  |  |
| Fibromyalgia |  |  |  |  |
| Chronic pelvic pain |  |  |  |  |
| Chronic low back pain |  |  |  |  |
| Vulvodynia or chronic vaginal pain |  |  |  |  |
| Chronic fatigue |  |  |  |  |
| Irritable bowel syndrome |  |  |  |  |
| Pelvic floor muscle myalgia OR dysfunction |  |  |  |  |
| Interstitial cystitis/ painful bladder syndrome |  |  |  |  |
| Migraine headaches |  |  |  |  |
| Post-traumatic stress disorder (PTSD) |  |  |  |  |
| Depression |  |  |  |  |
| Bipolar disorder |  |  |  |  |
| Eating disorder (Anorexia, Bulimia) |  |  |  |  |
| Anxiety |  |  |  |  |
| Military sexual trauma |  |  |  |  |
| Temporomandibular joint disorder, TMD or TMJ |  |  |  |  |
| Gynecologic cancer (uterus, ovary, or cervix) |  |  |  |  |
| Colon cancer |  |  |  |  |
| Breast cancer |  |  |  |  |
| Bladder cancer |  |  |  |  |
| Hypertension |  |  |  |  |
| Diabetes |  |  |  |  |
| Obesity |  |  |  |  |
| Clots or stroke |  |  |  |  |
| Heart attack or cardiovascular disease |  |  |  |  |

1. **Please list all CURRENT medications you are taking:**

|  |  |
| --- | --- |
| **Medication** | **Dose** |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

1. **Have you ever had any pelvic or abdominal surgery? Please check *all* that apply to YOU:**

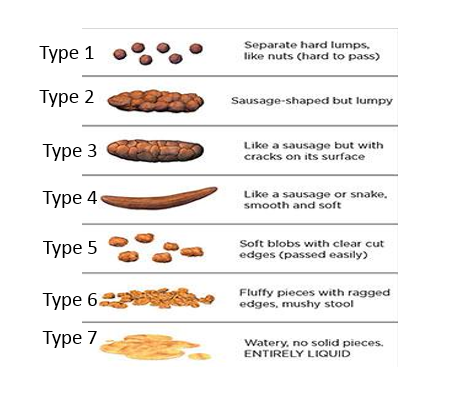
|  |  |  |  |
| --- | --- | --- | --- |
| **Procedure** | | **Year** | **Findings/Diagnoses** |
| **Cystoscopy**  (looking inside the bladder) | Yes  No | Click or tap here to enter text. | Click or tap here to enter text. |
| **Laparoscopy** (surgery using a small camera through the belly button)  What was the reason for the laparoscopy?  To remove endometriosis  To remove ovarian cysts  To remove adhesions  Other:Click or tap here to enter text. | Yes  No  Yes  Yes  Yes | Click or tap here to enter text. |  |
| **Hysterectomy** (removal of the uterus)  How was the hysterectomy done?  Through the vagina, through the abdomen with a big cut, or through the belly button with laparoscopy or robotics?  Was one ovary removed?  Were both ovaries removed?  Was the cervix removed?  Unsure about what was removed. | Yes  No  Vagina  Abdomen  Belly button  Don’t know  Yes  Yes  Yes  Unsure | Click or tap here to enter text. | Click or tap here to enter text. |
| **Myomectomy** (removal of fibroids while saving the uterus)  How was the myomectomy done, through the abdomen with a big cut or with laparoscopy or robotics through the belly button? | Yes  Abdomen  Belly button, laparoscopy  Belly button, robotics | Click or tap here to enter text. | Click or tap here to enter text. |
| **Appendectomy** (appendix removal)  How was the appendectomy done, through the abdomen with a big cut or with laparoscopy through the belly button? | Yes  No  Abdomen  Belly button | Click or tap here to enter text. | Click or tap here to enter text. |
| **Colectomy** (removal of colon) | Yes  No | Click or tap here to enter text. | Click or tap here to enter text. |
| **Tubal ligation or removal of tubes for permanent contraception** | Yes  No | Click or tap here to enter text. | Click or tap here to enter text. |
| **Other procedure:**Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. |

***NEXT LET’S FOCUS MORE ON SYMPTOMS OR PROBLEMS THAT YOU MAY BE EXPERIENCING***

1. **Are you experiencing any of these BOWEL symptoms? Check *all* that apply.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptom | Timing  Rarely: less than once a month  Sometimes: at least once or twice a month  Always: at least once or twice a week | | Severity  Mild does not make you stop doing activities  Moderate bothers you enough to stop what you are doing and use home remedies  Severe makes you stop activities and use prescribed medications or see a healthcare provider | Duration |
| Nausea | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Vomiting | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Reflux/Heartburn | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Bloating | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Diarrhea | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Constipation | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Pain before, during or after bowel movements | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Blood in stool | Yes  No | Rarely  Sometimes  Always | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |

**29a. What do your stools look like MOST of the time? Select *one* type from the chart**



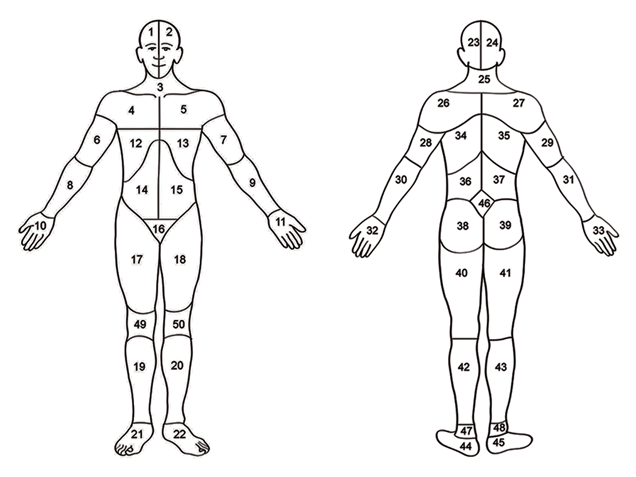
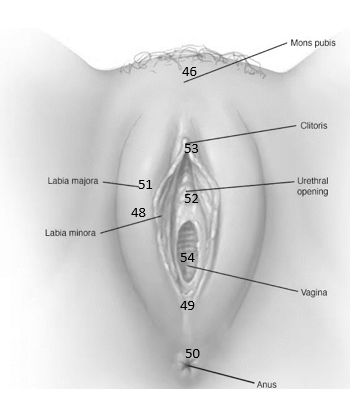
1. **Do you experience any of the following URINARY SYMPTOMS? *(Check all that apply)***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Symptom | Timing  Rarely: less than once a month  Sometimes: at least once or twice a month  Always: at least once or twice a week | | Severity  Mild does not make you stop doing activities  Moderate bothers you enough to stop what you are doing and use home remedies  Severe makes you stop activities and use prescribed medications or see a healthcare provider | | Duration |
| Loss of urine when coughing, sneezing or laughing | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Difficulty passing urine or starting a stream | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Still feeling full after you urinate | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Frequent bladder infections | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Blood in urine | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Having to urinate again within minutes of urinating | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |
| Sensation of a vaginal bulge or mass | Yes  No | Rarely  Sometimes  Always | | Mild  Moderate  Severe | 3 months or less  3 to 6 months  7 months to 1 year  2-9 years  More than 10 years |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **30a. 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 YOU HAVE PROBLEMS WITH ABDOMINAL, PELVIC, LOW BACK, OR VAGINAL PAIN, PLEASE TELL US MORE ABOUT YOUR PAIN.***

1. **Do you have problems with pain?** Yes No, ***SKIP TO QUESTION 57***
2. **Please write in the NUMBERS FOR ALL THE AREAS WHERE YOU HAVE PAIN. Use the body maps below and START WITH YOUR MOST PAINFUL AREA FIRST (you may also circle or shade painful areas):**Click or tap here to enter text.

****

1. **Indicate on this line by checking a box to describe how bad your MAIN pain is:**

|  |
| --- |
| 0  1 2 3 4 5 6 7 8 9 10 |

**No Pain Worse imaginable pain**

1. **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** | | | |
| **1** (for pain that is in the pelvis) | 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 |

**When you think of your worse pain, that is, the pain you are seeking medical treatment for…**

1. **When did your pain start?** Month:Click or tap here to enter text. Year:Click or tap here to enter text. Unsure
2. **How did your pain begin? *(Check only one)*** Suddenly Gradually over time
3. **How long has your main pain been present? *(Check only one)***

Less than 3 months 3-6 months 6-12 months 12 months-2 years 2-5 years More than 5 years

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

No different Getting better Getting worse I don’t know

1. **How did your main pain start, 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 During the military After the military

After surgery Cancer Medical condition

No obvious cause/ do not know a specific incident

Other:

1. **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)

1. **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:

1. **Does your pain ever wake you up from your sleep?** Yes No
2. **Does your pain ever radiate or spread to other regions of your body?**  Yes No
3. **What makes your pain WORSE? *(Check all that apply)***

Walking Climbing stairs Urination Heavy lifting

Full bladder Stress Housework The weather Getting in/out of the car Contact with clothing

Exercise Menstrual period

Intercourse/ Sexual contact

Bowel movements Other:Click or tap here to enter text.

Nothing makes it worse

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

Lying down/rest Emptying bladder Ice or Heating pad

Meditation Laxatives/enema It goes away by itself

Hot bath Massage Bowel movements

Exercise Ibuprofen or Tylenol Prescription pain medications

When my stress is low Nothing makes it better Other:Click or tap here to enter text.

When I feel supported Being distracted, when I am busy doing other things

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

Pain Intensity Scale Short Form 3a

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 |

1. **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 |

1. **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 you are sexually active*, please rate the impact of your pain on your sexuality.**

PROMIS Sexual Function Profile v1.0-Female

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 |

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?** |
| GnRH Modulators (Lupron®, Orilissa®) | Yes No | Yes No | Yes No Somewhat |
| Hormone IUD (Mirena®, Skyla®, Kyleena®) | Yes No | Yes No | Yes No Somewhat |
| 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:Click or tap here to enter text. | | | |

1. **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:Click or tap here to enter text.

1. **In the past YEAR how many times have you been to the ER to get treated for this pain?**

0  1 2 3 4 5 6 7 8 9 10 11 or more times

***LET’S FINISH OFF WITH AN ASSESSMENT OF YOUR MENTAL AND GENERAL HEALTH.***

1. **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 |

1. ***Please tell us ABOUT YOUR GENERAL HEALTH by marking 1 box per row.***

PROMIS Global Health v.1.1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 | | | | |
|  |  | | | | |

***THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. THIS INFORMATION WILL HELP YOUR CLINICIAN TAKE BETTER CARE OF YOU.***

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**FOR OFFICE USE ONLY:**

Form reviewed by (Name):Click or tap here to enter text.

Date of Review: Click or tap to enter a date.

Entered into database on:Click or tap to enter a date.