

Pelvic Pain Assessment Form

Physician: _____

Initial History and Physical Exam

Date: _____

Contact Information

Name: _____ Birth Date: _____ Chart Number: _____
 Phone: Work: _____ Home: _____
 Is there an alternate contact if we cannot reach you? _____
 Alternate contact phone number: _____

Information About Your Pain

Please describe your pain problem: _____
 What do you think is causing your pain? _____
 What does your family think is causing your pain? _____
 Do you think anyone is to blame for your pain? Yes No If so, who? _____
 Do you think surgery will be necessary? Yes No
 Is there an event that you associate with the onset of pain? Yes No If so, what? _____
 How long have you had this pain? < 6 months 6 months – 1 year 1 – 2 years > 2 years

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 present pain?	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation (mid-cycle)	<input type="radio"/>										
Pain level just before period	<input type="radio"/>										
Pain (not cramps) with period	<input type="radio"/>										
Deep pain with intercourse	<input type="radio"/>										
Pain in groin when lifting	<input type="radio"/>										
Pelvic pain lasting hours or days after intercourse	<input type="radio"/>										
Pain when bladder is full	<input type="radio"/>										
Muscle/joint pain	<input type="radio"/>										
Ovarian pain	<input type="radio"/>										
Level of cramps with period	<input type="radio"/>										
Pain after period is over	<input type="radio"/>										
Burning vaginal pain with sex	<input type="radio"/>										
Pain with urination	<input type="radio"/>										
Backache	<input type="radio"/>										
Migraine headache	<input type="radio"/>										
What would be an acceptable level of pain?	<input type="radio"/>										

What is the worst type of pain that you have ever experienced?

<input type="checkbox"/> Kidney stone	<input type="checkbox"/> Bowel obstruction	<input type="checkbox"/> Migraine headache
<input type="checkbox"/> Labor & delivery	<input type="checkbox"/> Current pelvic pain	<input type="checkbox"/> Backache
<input type="checkbox"/> Broken bone	<input type="checkbox"/> Surgery	
<input type="checkbox"/> Other _____		

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
 Bachelor's degree Postgraduate degree

What kind of work are you trained for? _____

What type of work are you doing? _____

Health Habits

Do you get regular exercise? Yes No Type: _____

What is your diet like? _____

What is your caffeine intake (number per day, include coffee, tea, soft drinks, etc.)? 0 1-3 4-6 >6

How many cigarettes do you smoke per day? _____ How many years? _____

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your drinking, or about something you said or did while you were drinking? Yes No

Have you ever taken a morning "eye-opener" drink? Yes No

What is your use of recreational drugs? Never used Used in past, but not now Presently using Choose not to answer

- Heroin Amphetamines Marijuana
- Barbiturates Cocaine Other _____

Have you ever received treatment for substance abuse? Yes No

Coping Mechanisms

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

- Spouse/Partner Relative Support Group Clergy
- Friend Doctor/Nurse Mental Health Professional 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 of the problems or stresses in your life, how does your pain compare in importance?

- The most important problem Just one of several/many problems

Menses

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 last menses? _____
Do you have any pain with your periods? Yes No
Does pain start the day flow starts? Yes No
Starts _____ days before flow starts: Yes No
Are periods regular? Yes No
Do you pass any clots in menstrual flow? Yes No

Bladder

Do you experience any of the following:

Loss of urine when coughing, sneezing, or laughing? Yes No
Frequent urination? Yes No
Need to urinate with little warning? Yes No
Difficulty passing urine? Yes No
Frequent bladder infections? Yes No
Frequency of nighttime urination: 0-1 2 or more Volume: Small Medium Large
Frequency of daytime urination: 8 or less 9-15 >16 Volume: Small Medium Large
Do you still feel full after urination? Yes No

Bowel

Is there discomfort or pain associated with a change in the consistency of the stool (i.e., softer or harder)? Yes No
Would you say that at least one-fourth (¼) of the occasions or days in the last 3 months you have had any of the following
(Check *all* that apply)

- Fewer than three bowel movements *a week* (0-2 bowel movements)
- More than three bowel movements *a day* (4 or more bowel movements)
- Hard or lumpy stools
- Loose or watery stools
- Straining during a bowel movement
- Urgency – having to rush to the bathroom for a bowel movement
- Feeling of incomplete emptying after a bowel movement
- Passing mucus (white material) during a bowel movement
- Abdominal fullness, bloating, or swelling

¹ The Functional Gastrointestinal Disorders, Drossman, et al. Chapter 4, “Functional Bowel Disorders and Functional Abdominal Pain”. 1994.

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

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.

Type	What does your pain feel like?			
	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	_____	_____	_____	_____

Melzack, R: The Short-Form McGill Pain Questionnaire, Pain 30:191-197, 1987

Which statement(s) below best describes how you cope with the pain? Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> I count numbers in my head or run a song through my mind | <input type="checkbox"/> I tell myself to be brave and carry on despite the pain |
| <input type="checkbox"/> I just think of it as some other sensation, such as numbness | <input type="checkbox"/> I tell myself that it really doesn't hurt |
| <input type="checkbox"/> I pray to God it won't last long | <input type="checkbox"/> I worry all the time about whether it will end |
| <input type="checkbox"/> I do something active, like household chores or projects | <input type="checkbox"/> I take pain medication |
| <input type="checkbox"/> I ignore it as best I can | <input type="checkbox"/> Other |

SF-36

In general, would you say your health is: Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your health in general now?

- | | |
|---|--|
| <input type="radio"/> Much better now than one year ago | <input type="radio"/> Somewhat worse now than one year ago |
| <input type="radio"/> Somewhat better now than one year ago | <input type="radio"/> Much worse than one year ago |
| <input type="radio"/> About the same as one year ago | |

The following items are about activities you might do during a typical day. *Does your health now limit you in these activities? If so, how much?*

- Vigorous activities, such as running, lifting heavy object, participating in strenuous sports
- Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
- Lifting or carrying groceries
- Climbing several flights of stairs
- Climbing one flight of stairs
- Bending, kneeling, or stooping
- Walking more than a mile
- Walking several blocks
- Walking one block
- Bathing or dressing yourself

Yes, limited a lot	Yes, limited a little	No	Not limited at all

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *because of your physical health*?

- Cut down the amount of time you spent on your work or other activities Yes No
 Accomplish less than you would like Yes No
 Were limited in the kind of work or other activities Yes No
 Had difficulty performing the work or other activities (for example, it took extra effort) Yes No

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *because of any emotional problems* (such as feeling depressed or anxious)?

- Cut down the amount of time you spent on work or other activities Yes No
 Accomplished less than you would like Yes No
 Didn't do work or other activities as carefully as usual Yes No

During the *past 4 weeks*, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friend, neighbors, or groups?

- Not at all Slightly Moderately Quite a bit Extremely

How much bodily pain have you had during the past 4 weeks?

- None Very mild Mild Moderate Severe Very severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all A little bit Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you *during the past 4 weeks*. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the *past 4 weeks*:

- Did you feel full of pep?
 Have you been a very nervous person?
 Have you felt so down in the dumps that nothing could cheer you up?
 Have you felt calm and peaceful?
 Did you have a lot of energy?
 Have you felt downhearted and blue?
 Did you feel worn out?
 Have you been a happy person?
 Did you feel tired?

All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time

During the *past 4 weeks*, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.?)

- All of the time Most of the time Some of the time A little of the time None of the time

How TRUE or FALSE is each of the following statements for you?

- I seem to get sick a little easier than other people
 I am as healthy as anybody I know
 I expect my health to get worse
 My health is excellent

Definitely True	Mostly True	Don't Know	Mostly False	Definitely False

Personal History

What would you like to tell us about your pain that we have not asked? Comments: _____

What types of treatments have you tried in the past for this pain? Acupuncture Homeopathic medicine Physical therapy

- | | | |
|---|---|---|
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Lupron, Zoladex, Synarel | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Anti-seizure medications | <input type="checkbox"/> Massage | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Meditation | <input type="checkbox"/> Skin magnets |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Naturopathic medications | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Danazol (Danocrine) | <input type="checkbox"/> Nerve blocks | <input type="checkbox"/> Trigger point injections |
| <input type="checkbox"/> Depo-Provera | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Family Practitioner | <input type="checkbox"/> Nonprescription medicine | |
| <input type="checkbox"/> Herbal medication | <input type="checkbox"/> Nutrition/diet | |

What physicians or health care providers have evaluated or treated you for chronic pelvic pain? Include all healthcare professionals, whether they were physicians or not. Do you have any objections to me contacting these healthcare providers? Yes No

<i>Physician/Provider</i>	<i>City, State</i>

Who is your primary care physician? _____

Please list all surgical procedures you've had (*related to this pain*):

<i>Year</i>	<i>Procedure</i>	<i>Surgeon</i>

Please list all other surgical procedures:

<i>Year</i>	<i>Procedure</i>

<i>Year</i>	<i>Procedure</i>

Please list pain medications you've taken for your pain condition in the past 6 months, and the physicians who prescribed them (use separate page if necessary):

<i>Medication</i>	<i>Physician</i>	<i>Did it help?</i>
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> I have written more medications on a separate page		

Have you ever been hospitalized for anything besides surgery or childbirth? Yes No If yes, explain: _____

Have you had major accidents such as falls or back injury? Yes No

Have you ever been treated for depression? Yes No Treatments: Medication Hospitalization Psychotherapy

Birth control method: Nothing Pill Vasectomy Hysterectomy
 IUD Rhythm Diaphragm Tubal Ligation
 Condom Other: _____

Is future fertility desired? Yes No

How many pregnancies have you had? _____

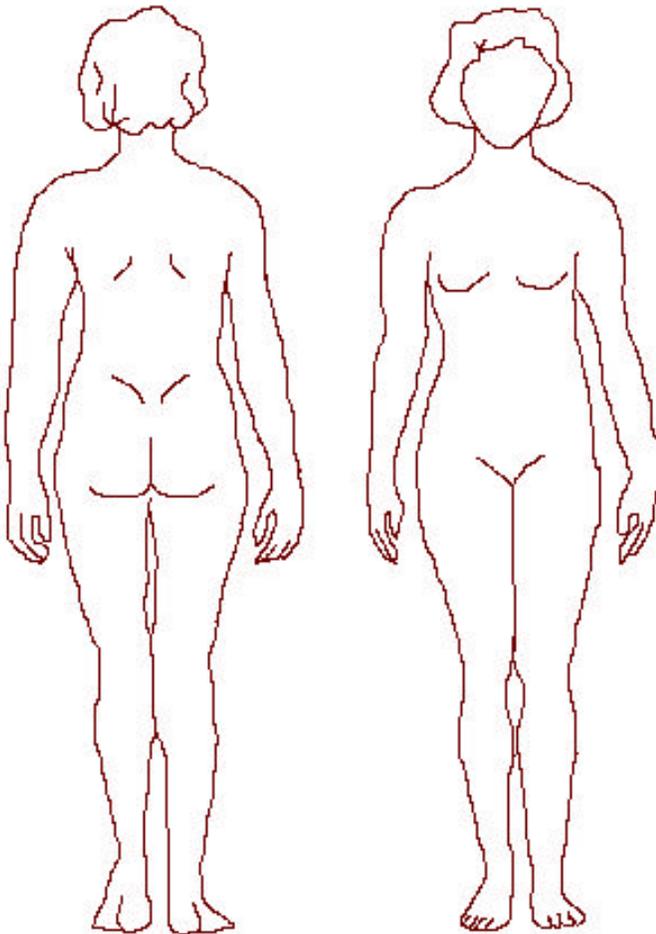
Resulting in (#): _____ Full 9 month _____ Premature _____ Abortions (miscarriage) _____ # living children

Any complications during pregnancy, labor, delivery, or post partum period?

- 4° Episiotomy C-section Post-partum hemorrhaging
 Vaginal lacerations Forceps Medication for bleeding
 Other: _____

Has anyone in your family ever had:

<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Chronic pelvic pain	<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Interstitial cystitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Recurrent Urinary Tract Infections		



Place an "X" at the point of your most intense pain.
Shade in all other painful areas.

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

		As a child (13 and younger)		As an adult (14 and over)	
Circle an answer for <u>both</u> as a child and as an adult.					
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 ever 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? If yes, please specify: _____	Yes	No	Yes	No
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 21:141-148, 1995

Physical Examination – For Physician Use Only

Name: _____ Chart Number: _____

Height: _____ Weight: _____ BP: _____ LMP: _____ Temp: _____ Resp: _____

ROS, PFSH Reviewed: Yes No Physician Signature _____

General: WNL Walk Facial expression
 Color Alterations in posture Other _____

NOTE: Mark "Not Examined" as N/E

HEENT WNL _____ Chest WNL _____ Heart WNL _____ Breasts WNL _____

Abdomen

- Non-tender Incisions Trigger Points Ovarian point tenderness
- Inguinal tenderness Inguinal bulge Suprapubic tenderness Other _____

Back

- Non-tender Tenderness Altered ROM Alterations in posture

Extremities

- WNL Edema Varicosities Neuropathy Range of motion

Neuropathy

- Iliohypogastric Ilioinguinal Genitofemoral Pudendal Altered sensation

EGBUS/Vagina

- WNL Lesions
- Wet prep:
- Local tenderness:
- Vaginal mucosa:
- Posterior fourchette:
- Discharge:
- Cultures:
 - GC Chlamydia Fungal Herpes



Patient rates allodynia produced by Q-tip for each circle (0-4).
Total Score: _____

Unimanual pelvic exam

- WNL Cervix
- Introitus Cervical motion
- Uterine-cervical junction Parametrium
- Urethra Vaginal cuff
- Bladder Cul de sac
- R ureter L ureter
- R inguinal L inguinal
- Muscle awareness Clitoral tenderness

Rank muscle tenderness on 0-4 scale

- R obturator _____
- L obturator _____
- R piriformis _____
- L piriformis _____
- R pubococcygeus _____
- L pubococcygeus _____
- Total pelvic floor score _____

Bimanual pelvic exam

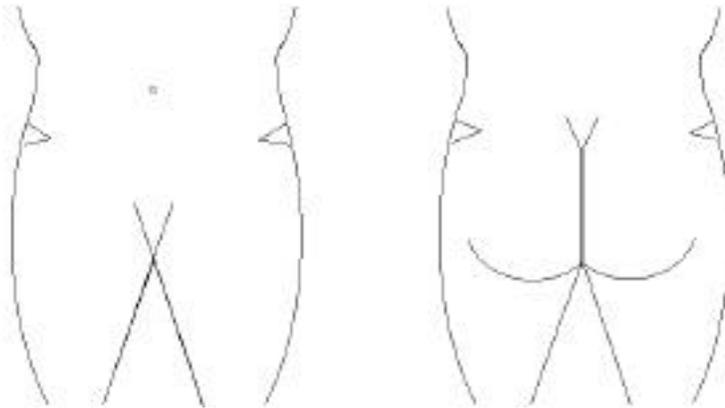
- | | | | |
|-------------|---|--------------------------------------|--------------------------------------|
| Uterus: | <input type="checkbox"/> Absent | <input type="checkbox"/> Non-tender | <input type="checkbox"/> Midplane |
| Position | <input type="checkbox"/> Tender | <input type="checkbox"/> Posterior | |
| Size | <input type="checkbox"/> Anterior | <input type="checkbox"/> Other _____ | |
| Contour | <input type="checkbox"/> Normal | <input type="checkbox"/> Irregular | <input type="checkbox"/> Other _____ |
| Consistency | <input type="checkbox"/> Regular | <input type="checkbox"/> Soft | <input type="checkbox"/> Hard |
| Mobility | <input type="checkbox"/> Firm | <input type="checkbox"/> Hypermobile | <input type="checkbox"/> Fixed |
| Support | <input type="checkbox"/> Mobile | <input type="checkbox"/> Prolapse | |
| | <input type="checkbox"/> Well supported | | |

Adnexae

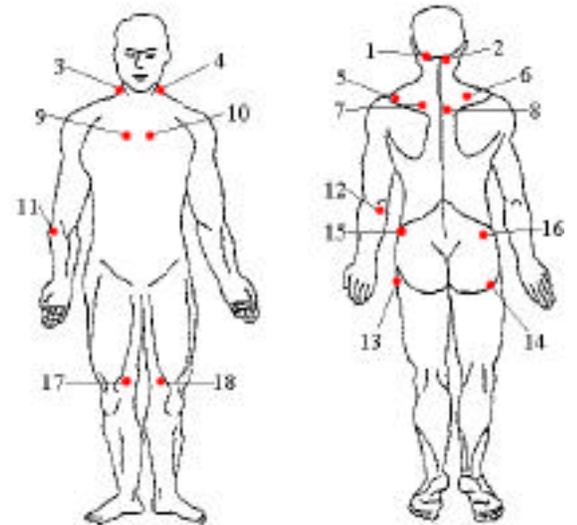
- | | | | |
|-------|--|------|--|
| Right | <input type="checkbox"/> Absent | Left | <input type="checkbox"/> Absent |
| | <input type="checkbox"/> WNL | | <input type="checkbox"/> WNL |
| | <input type="checkbox"/> Tender | | <input type="checkbox"/> Tender |
| | <input type="checkbox"/> Fixed | | <input type="checkbox"/> Fixed |
| | <input type="checkbox"/> Enlarged _____ cm | | <input type="checkbox"/> Enlarged _____ cm |

Rectovaginal

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> WNL | <input type="checkbox"/> Nodules | <input type="checkbox"/> Guaiac positive |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Mucosal pathology | (negative with quality control) |
| <input type="checkbox"/> Not examined | | |



Trigger Points



Fibromyalgia

Assessment: _____

Diagnostic Plan: _____

Therapeutic Plan: _____



Dear Healthcare Professional:

The Research Committee, headed by Deborah Metzger, M.D., Ph.D., along with the Board of Directors of The International Pelvic Pain Society are proud to present this Pelvic Pain Assessment Form for use in the medical community. This form has been developed by clinicians who treat chronic pelvic pain on a daily basis, and is the culmination of two year's effort. We hope that you find it useful.

The Pelvic Pain Assessment Form is designed to be printed front and back to yield a total of 10 pages on 5 sheets, for your convenience.

It is our desire that this form become a standard in your intake procedures. We solicit your constructive comments. It is only by open communication from the clinician who uses this form consistently that we will improve it. You can phone your comments to the number shown on the form, or e-mail us at pelvicpain@aol.com.

Sincerely,
C. Paul Perry, M.D.,
Chairman of the Board of Directors

Deborah Metzger, M.D., Ph.D.
Chairperson, Research Committee
