PELVIC PAIN QUESTIONAIRE

Please complete this Pelvic Pain Questionnaire and return to our rooms prior to your appointment. In the interim it may be helpful for you to visit the Pelvic Pain Foundation of Australia website for more information on Pelvic Pain.

The PPFA website at www.pelvicpain.org.au has a wide range of information for girls, women and men with Pelvic Pain. We know it can be difficult to get the information you need about Pelvic Pain, so please feel free to download and read this free e-booklet by clicking on the link below:

https://www.drsusanevans.com.au/publications/books/pelvic-pain-booklet-2017/

Title:	Dr		Mr		Mrs		Miss		Date of Birth:		
Surname:									Given Name:		
Are you currently:	Single		Married		De-Facto		Separated		Divorced		Same Sex
What type of employment are you currently in?									How Long?		
Who do you live with?											

INFORMATION ABOUT YOUR PAIN

Please describe your pain problem?				
What do you think is causing your pain?				
Is there an event that you associate with the onset of your pain?	Yes		No	
If so, what is this event?				
How long have you had this pain?	Years		Months	

For each of the symptoms listed below, please rate your pain on a scale of:

0 = no pain to 10 = worst imaginable **(please circle)**

1.	Pain at ovulation (mid-cycle)	0	1	2	3	4	5	6	7	8	9	10
2.	Pain just before period	0	1	2	3	4	5	6	7	8	9	10
3.	Pain (not cramps) before period	0	1	2	3	4	5	6	7	8	9	10

4.	Deep pain with intercourse	0	1	2	3	4	5	6	7	8	9	10
5.	Pain in groin when lifting	0	1	2	3	4	5	6	7	8	9	10
6.	Pelvic pain last hours or days after intercourse	0	1	2	3	4	5	6	7	8	9	10
7.	Pain when bladder is full	0	1	2	3	4	5	6	7	8	9	10
8.	Muscle / Joint Pain	0	1	2	3	4	5	6	7	8	9	10
9.	Level of cramps with period	0	1	2	3	4	5	6	7	8	9	10
10.	Pain after period is over	0	1	2	3	4	5	6	7	8	9	10
11.	Burning vaginal pain after sex	0	1	2	3	4	5	6	7	8	9	10
12.	Pain with urination	0	1	2	3	4	5	6	7	8	9	10
13.	Backache	0	1	2	3	4	5	6	7	8	9	10
14.	Migraine Headache	0	1	2	3	4	5	6	7	8	9	10
15.	Pain with sitting	0	1	2	3	4	5	6	7	8	9	10

WHAT OTHER PHYSIANS OR HEALTH CARE PROVIDERS HAVE EVALUATED OR TREATED YOU FOR CHRONIC PELVIC PAIN?

Health Care Provider Name	Specialty	State & Contact – If known

WHAT TYPES OF PRACTITIONERS OR TREATMENTS HAVE YOU TRIED IN THE PAST FOR YOUR PAIN?

	Acupuncture		Herbal Medicine		Osteopathy
	Anaesthesiologist		Homeopathic Medicine		Physiotherapy
	Anti-seizure medications		Lupron, Synarel, Zoladex		Psychotherapy
	Antidepressants		Massage		Psychiatry
	Botox Injections		Meditation		Rheumatologist
	Chiropractor		Narcotics		Skin Magnets
	Contraceptive pills / patch / ring		Naturopathic medication		Surgery
	Danazol (Danocrine)		Nerve blocks		TENS Unit
	Gastroenterologist		Neurosurgeon		Trigger point injections
	General Practitioner		Non-prescription medicine		Urologist
	Gynaecologist		Nutrition/diet		Other:

MENSTRAL HISTORY:

At what age did you have your first menstrual period?	Are you still having menstrual periods?			
	Yes		No	

Please 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?			Days	
Date of first day of your last menstrual period?				

Are your periods regular?	Yes	No	Does pain start the day flow starts?	Yes	No
Pain with periods?	Yes	No	Do you pass clots in your menstrual flow?	Yes	No
Do you have spotting in between periods?	Yes	No	Have you had bleeding after sex?	Yes	No

Birth Control Method:					
Nothing	Vaginal Ring	Depo Provera	Tubal Sterilisation	Hysterectomy	IUD
Pill	Vasectomy	Diaphragm	Condom	Other:	

MEDICAL HISTORY:

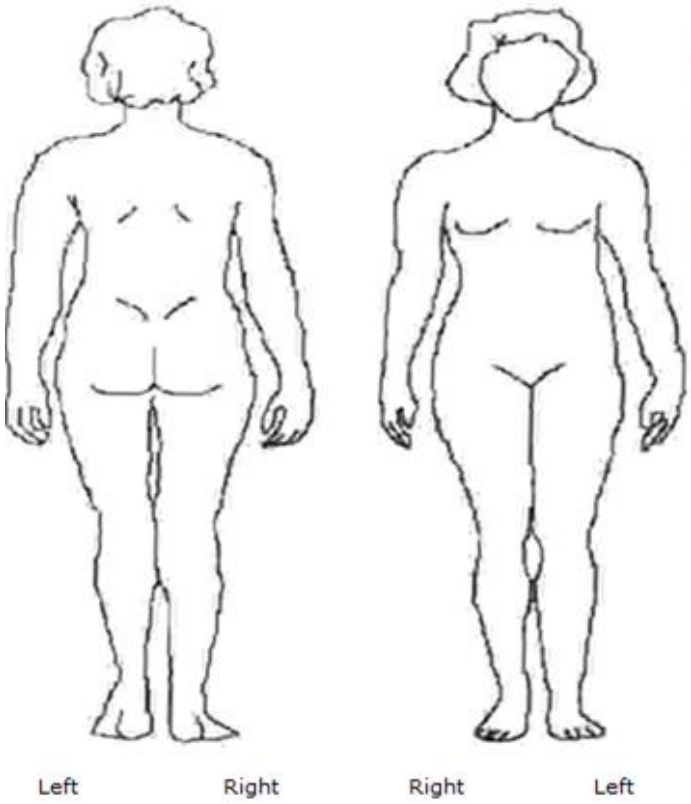
Medical Problem/Diagnoses	Treatment including Surgeries

**Allergies	Describe in detail the reaction

Who is your Primary Care Provider?		
Have you been hospitalized for anything besides Childbirth?	Yes	No
If yes, please provide details:		
Have you had any major accidents such as falls or a back injury?	Yes	No
Have you ever been treated for depression or anxiety?	Yes	No
If yes, which treatment? ***Please circle or tick one***		
Medication / Hospitalisation / Psychotherapy		
Other:		

PAIN MAPS:

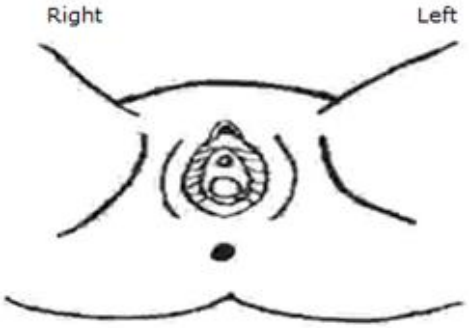
Please shade areas of pain and write a number from 1 to 10 at the site(s) of pain with 10 = worst imaginable



Vulval/ Perineal Pain is pain outside and around the vagina and anus.

If you have vulval pain, shade the painful areas and write a number from 1 to 10 at the painful sites (10 = most severe pain imaginable)

Is your pain relieved by sitting forward or off to the side which distributes your weight off the buttocks? Yes / No



PREGNANCY HISTORY: Number of pregnancies including miscarriages, terminations, ectopic pregnancies and deliveries

Year	Place	Gestation (weeks)	Labor, Birth & Post Natal Details	Birth Weight	Gender	Breast/Bottle	Name

Were there any complications during pregnancy, labor, delivery or post-partum?	Yes	No

Caesarean Section?	Yes	No
Forceps?	Yes	No
Episiotomy?	Yes	No
Vaginal Laceration?	Yes	No
Post-partum hemorrhage?	Yes	No
Medication for Bleeding?	Yes	No
Other:		

FAMILY HISTORY: Has anyone in your family had?

Fibromyalgia	Chronic Pelvic Pain	Irritable Bowel Syndrome	Endometriosis
Cancer	Interstitial Cystitis	Depression / Anxiety	
If Cancer, what type?:			
Other Chronic Condition:			

List all Surgical Procedures you have had **RELATED** to this pain:

Year(s)	Procedure	Surgeon	Findings

List all Surgical Procedures **NOT** related to this pain:

Year(s)	Procedure	Surgeon	Findings

MEDICATION HISTORY:

Medication	Dose	Frequency	Did it help?		
			Yes	No	Currently Taking
			Yes	No	Currently Taking
			Yes	No	Currently Taking
			Yes	No	Currently Taking

HEALTH HABITS

How often do you exercise?	Daily	1-2 times per week	3-5 times per week	Rarely
What is your caffeine intake? Number of cups per day including coffee, tea and soft drink				Cups per day

Do you smoke?	Yes	No	Drink Alcohol?	Yes	No
If yes, how many		per day	If yes, standard drinks		per week
Are you an ex-smoker?	Yes	No			

Have you ever received treatment for substance abuse?			Yes	No
What is your use of recreational drugs?	Never Used	Used in the past	Currently Using	
If used in the past or currently using, which?				
Heroin	Cocaine	Marijuana	Barbiturates	Amphetamines
Other:				

EATING

How would you describe your diet? Tick all that apply				
Well Balanced	Vegan	Vegetarian	Fatty or Fried Foods	Special Diet
Other:				
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

GASTROINTESTINAL

Are you experiencing rectal bleeding or blood in your stool?	Yes	No
Do you have increased bowel movements?	Yes	No

The following questions assist to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain.

Do you have pain or discomfort that is associated with the following?		
Change in frequency of bowel movement?	Yes	No
Change in appearance of stool or bowel movement?	Yes	No
Does your pain improve after a bowel movement?	Yes	No

URINARY SYMPTONS

Do you experience any of the following?		
Loss of urine when coughing, sneezing or laughing?	Yes	No
Difficulty passing urine?	Yes	No
Frequent bladder infections?	Yes	No
Blood in urine?	Yes	No

Still feeling full after urination?	Yes	No
Having to void again within minutes of voiding?	Yes	No

The following questions assist to diagnose painful bladder syndrome, which may cause pelvic pain.

Please circle the answer that best describes your bladder function and symptoms.					
	0	**1**	**2**	**3**	**4**
How many times do you go to the bathroom during the DAY?	3-6	7-10	11-14	15-19	20+
How many times do you go to the bathroom at NIGHT?	0	1	2	3	4+
If you get up at night to empty your bladder does it bother you?	Never	Mildly	Moderate	Severely	

Are you sexually active?			Yes	No
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
If you have pain associated with intercourse, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always
Do you have pain associated with bladder or in your pelvis (lower abdomen, labia, vagina, urethra, and perineum)?	Never	Occasionally	Usually	Always
Do you have urgency after voiding?	Never	Occasionally	Usually	Always
If you have pain, is it usually		Mild	Moderate	Severe
Does your pain bother you?	Never	Occasionally	Usually	Always
If you have urgency, is it usually		Mild	Moderate	Severe
Does your urgency bother you?	Never	Occasionally	Usually	Always

OTHER INFORMATION:

Other information you may wish to provide OR issues you may wish to address OR your expectations:

Remember to forward your completed New Patient Information Form and your completed Questionnaire back to us to enable Dr Preetam Ganu to review prior to your appointment
by fax **08 8299 0893** or email flindersobgyn@gmail.com