

# Pelvic Pain Assessment Form

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

*Initial History and Physical Examination*

This assessment form is intended to assist the clinician with the initial patient assessment and is not meant to be a diagnostic tool.

*Contact Information*

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Chart Number: \_\_\_\_\_  
 Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Referring Provider's Name and Address: \_\_\_\_\_

*Information About Your Pain*

Please describe your pain problem (use a separate sheet of paper if needed) : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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? \_\_\_\_\_

How long have you had this pain? \_\_\_\_ years \_\_\_\_ months

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

*Provider Comments*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



What physicians or health care providers have evaluated or treated you for **chronic pelvic pain**?

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

*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  
 College degree       Postgraduate degree

What type of work are you trained for? \_\_\_\_\_

What type of work are you doing? \_\_\_\_\_

*Surgical History*

Please list all surgical procedures you have had **related to this pain**:

Year	Procedure	Surgeon	Findings

Please list all **other** surgical procedures:

Year	Procedure

Year	Procedure

*Provider Comments*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications**

Please list **pain medication** you have taken for your pain condition in the past 6 months, and the providers who prescribed them (use a separate page if needed):

Medication / dose	Provider	Did it help?
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking

Please list all **other medications** you are presently taking, the condition, and the provider who prescribed them (use a separate page if needed):

Medication / dose	Provider	Medical Condition

**Obstetrical History**

How many pregnancies have you had? \_\_\_\_\_  
 Resulting in (#): \_\_\_\_\_ Full 9 months \_\_\_\_\_ Premature \_\_\_\_\_ Miscarriage / Abortion \_\_\_\_\_ Living children  
 Where there any complications during pregnancy, labor, delivery, or post partum?  
 4° Episiotomy  C-Section  Vacuum  Post-partum hemorrhaging  
 Vaginal laceration  Forceps  Medication for bleeding  Other \_\_\_\_\_

**Family History**

Has anyone in your family had:  Fibromyalgia  Chronic pelvic pain  Irritable bowel syndrome  
 Depression  Interstitial Cystitis  Other Chronic Condition \_\_\_\_\_  
 Endometriosis  Cancer, Type(s) \_\_\_\_\_

**Medical History**

Please list any medical problems / diagnoses \_\_\_\_\_  
 \_\_\_\_\_  
 Allergies (including latex allergy) \_\_\_\_\_  
 Who is your primary care provider? \_\_\_\_\_  
 Have you ever been hospitalized for anything besides childbirth?  Yes  No If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 Have you had major accidents such as falls or a back injury?  Yes  No  
 Have you ever been treated for depression?  Yes  No Treatments:  Medication  Hospitalization  Psychotherapy  
 Birth control method:  Nothing  Pill  Vasectomy  Vaginal ring  Depo provera  
 Condom  IUD  Hysterectomy  Diaphragm  Tubal Sterilization  
 Other \_\_\_\_\_

**Menstrual History**

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 first day of last menstrual period \_\_\_\_\_  
Do you have any pain with your periods?  Yes  No  
Does pain start the day flow starts?  Yes  No Pain starts \_\_\_\_\_ days before flow  
Are periods regular?  Yes  No  
Do you pass clots in menstrual flow?  Yes  No

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

*The following questions help 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 completing a bowel movement?  Yes  No

**Health Habits**

How often do you exercise?  Rarely  1-2 times weekly  3-5 times weekly  Daily  
What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)?  0  1-3  4-6  >6  
How many cigarettes do you smoke per day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
Do you drink alcohol?  Yes  No  
Number of drinks per week \_\_\_\_\_  
Have you ever received treatment for substance abuse?  Yes  No  
What is your use of recreational drugs?  Never used  Used in the past, but not now  Presently using  No answer  
 Heroin  Amphetamines  Marijuana  Barbiturates  Cocaine  Other \_\_\_\_\_  
How would you describe your diet? (check all that apply)  Well balanced  Vegan  Vegetarian  Fried food  
 Special diet \_\_\_\_\_  Other \_\_\_\_\_

*Urinary Symptoms*

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

The following questions help 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
1. How many times do you go to the bathroom <b>DURING THE DAY</b> (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 <b>AT NIGHT</b> (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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	

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KCl \_\_\_\_ Not Indicated \_\_\_\_ Positive \_\_\_\_ Negative

### *Coping Mechanisms*

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

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

- The most important problem       Just one of many problems

### *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<br>(13 and younger)                           | As an adult<br>(14 and over)                             |
|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| Check 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?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1b. Has anyone ever threatened to have sex with you when you did not want it?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1c. Has anyone ever touched the sex organs of your body when you did not want this?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1d. Has anyone ever made you touch the sex organs of their body when you did not want this?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1e. Has anyone forced you to have sex when you did not want this?                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1f. Have you had any other unwanted sexual experiences not mentioned above?<br>If yes, please specify _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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 1995;21:141-148.*

**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.

What does your pain feel like?

Type	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	_____	_____	_____	_____

*Melzak R. The Short-form McGill Pain Questionnaire. Pain 1987;30:191-197.*

**Pelvic Varicosity Pain Syndrome Questions**

- Is your pelvic pain aggravated by prolonged physical activity?  Yes  No
- Does your pelvic pain improve when you lie down?  Yes  No
- Do you have pain that is deep in the vagina or pelvis *during* sex?  Yes  No
- Do you have pelvic throbbing or aching *after* sex?  Yes  No
- Do you have pelvic pain that moves from side to side?  Yes  No
- Do you have sudden episodes of severe pelvic pain that come and go?  Yes  No