THE INTERNATIONAL PELVIC PAIN SOCIETY

Professionals engaged in pain management for women.

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

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

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

❑ Kidney stone ❑ Bowel obstruction ❑ Migraine headache

❑ Labor & delivery ❑ Current pelvic pain ❑ Backache

❑ Broken bone ❑ Surgery

❑ 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 <u>are</u> 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 (_) 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] <u>The Functional Gastrointestinal Disorders</u>, 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.

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				

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

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

- ○ Much better now than one year ago
- ○ Somewhat better now than one year ago
- ○ About the same as one year ago
- ○ Somewhat worse now than one year ago
- ○ Much worse than 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?*	Yes, limited a lot	Yes, limited a little	No	Not limited at all
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				

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*:	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
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?						

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

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

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

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

Physician/Provider	***City, State***

Who is your primary care physician? _____

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

Year	***Procedure***	***Surgeon***

Please list all other surgical procedures:

Year	***Procedure***

Year	***Procedure***

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):

Medication	***Physician***	***Did it help?***
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
❑ 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?_____

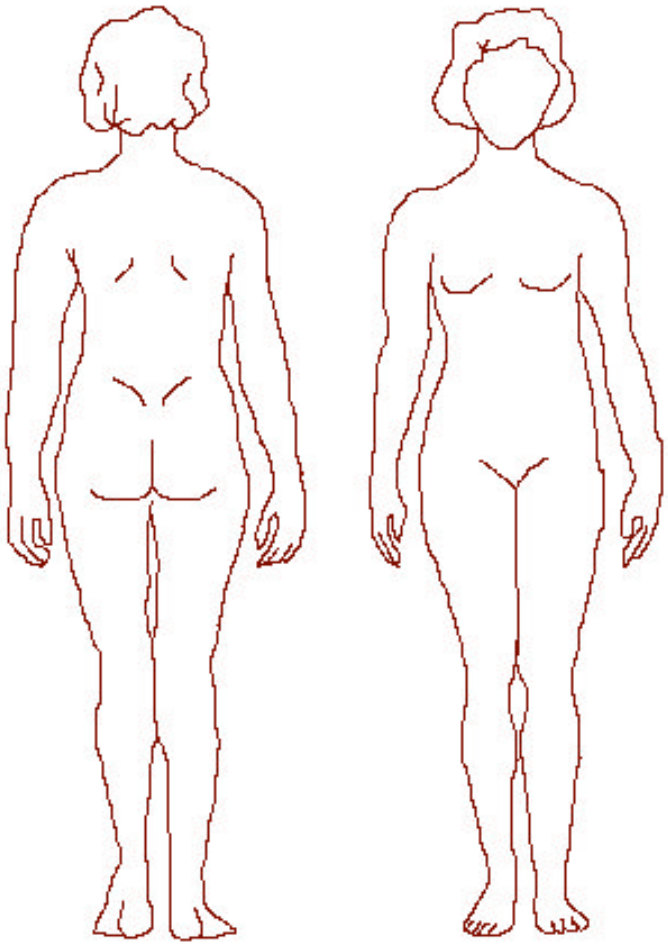
Resulting in (#): _____ Full 9 month _____ Premature _____ Abortions (miscarriage) _____ # living children

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:

❑ Fibromyalgia ❑ Chronic pelvic pain ❑ Scleroderma
❑ Endometriosis ❑ Lupus ❑ Interstitial cystitis
❑ Cancer ❑ Depression ❑ Irritable Bowel Syndrome
❑ 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 _____

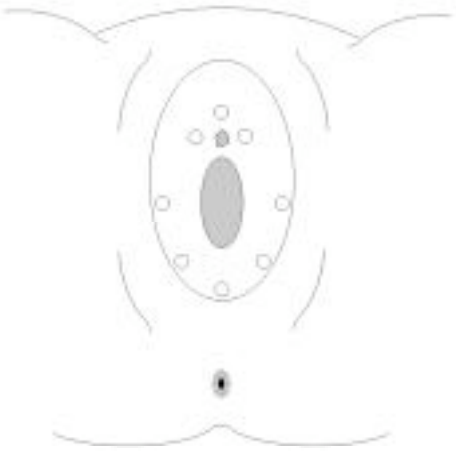
Back
❑ Non-tender ❑ Tenderness ❑ Altered ROM ❑ Alterations in posture

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

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



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

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 ❑ Absent

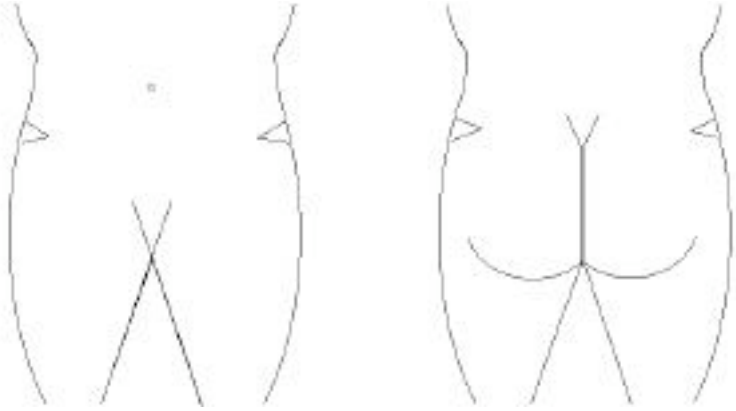
Uterus:	❑ Tender	❑ Non-tender	
Position	❑ Anterior	❑ Posterior	❑ Midplane
Size	❑ Normal	❑ Other _____	
Contour	❑ Regular	❑ Irregular	❑ Other _____
Consistency	❑ Firm	❑ Soft	❑ Hard
Mobility	❑ Mobile	❑ Hypermobile	❑ Fixed
Support	❑ Well supported	❑ Prolapse	

Adnexae

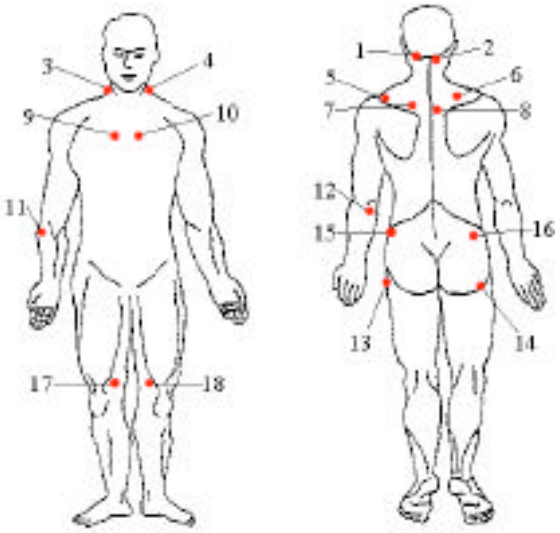
Right	Left
❑ Absent	❑ Absent
❑ WNL	❑ WNL
❑ Tender	❑ Tender
❑ Fixed	❑ Fixed
❑ Enlarged _____ cm	❑ Enlarged _____ cm

Rectovaginal

❑ WNL ❑ Nodules ❑ Guaiac positive (negative with quality control)
❑ Tenderness ❑ Mucosal pathology
❑ Not examined



Trigger Points



Fibromyalgia

Assessment: _____

_____

Diagnostic Plan: _____

_____

Therapeutic Plan: _____

_____