Name_____ DOB_____

Pelvic Pain Questionnaire, Page 1

1. Who referred you to our practice/how did you hear about our practice?

_____

2. Do you have history of diagnosed GI issues, such as ulcerative colitis, Crohn's, etc?

_____

3. Name of your gynecologist_____

4. Have you been treated for any GYN related issues, such as pelvic congestion, adenomyosis, or fibroids? If so, what was the treatment. If no treatment, wrist "none".

_____

5. If you were diagnosed with uterine fibroid and/or adenomyosis, when was this?

_____

6. Does anyone in your family have fibroids? _____

7. Do you have history of diagnosed urinary issues, such as interstitial cystitis, etc?

_____

8. Please list, if any, abdominal surgeries below. If you have never had any, write "none":

_____

9. Do you have any history of sexually transmitted infections? Please list below when, and how treated.

_____

Do you, or have you ever had :

Heavy menstrual bleeding:	☐Yes ☐No	Constipation:	☐Yes ☐No
Abdominal Pain:	☐Yes ☐No	Diarrhea:	☐Yes ☐No
Pelvic pain:	☐Yes ☐No	Painful intercourse:	☐Yes ☐No
Back pain:	☐Yes ☐No	Anemia:	☐Yes ☐No
Frequent urination:	☐Yes ☐No	Blood transfusion:	☐Yes ☐No

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Menstrual history

1. Last menstrual period date: _____
2. Number of days bleeding during menses: _____
3. Number of days of heavy bleeding during menses: _____
4. Gushing: ☐Yes ☐No
5. Passing clots: ☐Yes ☐No
6. Using: ☐Tampons ☐ Feminine pads ☐ Both
7. Cycle is : ☐ Regular ☐ Irregular
8. During heaviest bleeding how often do you change pad/tampon?
   Every _____hour(s).
9. Do you have any history of sexually transmitted infections (circle one): ☐ Yes ☐ No
10. Last Pap smear date: _____
11. Last pelvic exam date: _____
12. Have you ever had an abnormal Pap smear (circle one): ☐ Yes ☐ No
13. Endometrial biopsy? date: _____ Result was: ☐ Normal ☐ Abnormal
14. Pelvic ultrasound date:_____ Facility? _____
15. How many pregnancies have you had: _____
16. How many live births: _____
17. Do you desire future pregnancy (circle one): ☐ Yes ☐ No
18. What other treatment have you tried for your symptoms?

_____

19. Do you take birth control (circle one): ☐ Yes ☐ No
20. Name of birth control: _____
21. Do you have an IUD: ☐ Yes ☐ No
    If yes, what type of IUD_____
22. Do you receive Lupron or Depo Provera injections (circle one): ☐ Yes ☐ No
    If yes, what is the date of your last injection_____
23. Do you have a history of GYN cancer (cervical, ovarian, uterine, or other) ☐ Yes ☐No
    If yes, what type_____
    When were you diagnosed _____

Do you have:

Pelvic pain or aching around the pelvis and lower abdomen?	☐Yes	☐No
Heavy sensation in the pelvis?	☐Yes	☐No
Feeling of fullness in the legs?	☐Yes	☐No
Have you ever tried compression stockings?	☐Yes	☐No
Have you ever tried compression shorts?	☐Yes	☐No
Does leg elevation improve your symptoms?	☐Yes	☐No
Does laying down improve your symptoms?	☐Yes	☐No
Does compression improve your symptoms?	☐Yes	☐No

Is your pelvic pain/heaviness worse:
☐ In the morning ☐ In the evening ☐ All day ☐ With menses ☐ With or after intercourse
☐ No change

Do you feel any of the following in your legs?
☐ Aching ☐ Heaviness ☐ Itching ☐ Restlessness ☐ Swelling ☐ Cramping only while walking

Do you have:

Varicose veins in your legs?	☐ Right	☐ Left	☐ Both	☐ None
Skin color or texture changes in your legs?	☐ Right	☐ Left	☐ Both	☐ None
Open wounds or sores of the legs?	☐ Right	☐ Left	☐ Both	☐ None
Large visible veins of the labia?	☐ Right	☐ Left	☐ Both	☐ None

Do your symptoms affect quality of your life? ☐ Yes ☐ No

What activities are limited as a result of your symptoms?

_____

_____

_____

_____