Name_________________________________ DOB________________________

Pelvic Pain Questionnaire

Who referred you to our practice? __________________________________
OR
How did you hear about our practice? ________________________________

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
Worsening of stress incontinence ◯Yes ◯No
Lower leg pain / discomfort in the evening and/or at night? ◯Yes ◯No ◯Right ◯Left ◯Both
Pelvic pain / heaviness is worse:
◯in the morning ◯in the evening ◯all day ◯with menses ◯with or after intercourse
Do you feel any of the following in your legs?
◯ aching ◯ cramping ◯ heavy feeling ◯ swelling ◯ restless feeling ◯ itching
Does elevating your legs improve the pain? ◯Yes ◯No
Does laying down improve the pelvic pain? ◯Yes ◯No

Do you have

Varicose veins in your legs ◯Right ◯Left ◯Both
Skin color or texture changes in your legs ◯Right ◯Left ◯Both
Open wounds or sores of legs ◯Right ◯Left ◯Both
Large visible veins of the scrotum or labia ◯Right ◯Left ◯Both
Do your symptoms affect quality of your life? ◯Yes ◯No
What activities do you limit as a result of your symptoms?

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