WOMEN'S CENTER FOR PELVIC HEALTH

Women's Center for Pelvic Health
Mercy Medical Plaza
2001 Vail Ave. Suite 360
Charlotte, NC 28207

Dear Ms. _____

We understand that you have been referred to our clinic for abdominal, vulvar, or pelvic pain. Pain can often be a complicated and difficult problem, so the more information we can obtain the better our chance to help you. Because of this, we ask you to supply us with information about yourself prior to your appointment. Enclosed are questionnaires that we need to have you fill out and return to us. The questionnaires are about your general medical and surgical history and also about details of your pain history. We know these questionnaires are long, but they greatly help us with your evaluation and care. We require that these be completed prior to your appointment. If we have not received them by that time, we will need to cancel and reschedule your appointment.

Your first appointment will take 30-60 minutes.

We hope to understand your suffering and work to alleviate your pain. We look forward to meeting you and working with you to conquer your pain.

Yours truly,

Smitha Vilasagar, MD
Women's Center for Pelvic Health
Carolinas HealthCare System
O: 704-304-1160
F: 704-304-1162

REMINDER: You must return your questionnaire prior to your appointment or we will need to reschedule. Also, please copy the front and back of your insurance card and return with this packet. This helps us be sure your insurance is accepted and an authorization is in place if needed.

WOMEN'S CENTER FOR PELVIC HEALTH

Patient Registration **MRN**: _____

Patient Name _____ **DOB**: ____/____/____ **SSN**: _____-_____-_____

Address_____

City_____ **State**_____ **Zip**_____

Primary phone #_____ **Employer**_____

Secondary phone #_____ **Work phone** #_____

Emergency Contact_____ **Relationship**_____

Primary phone # _____

Secondary phone # _____

Other phone #_____

Primary Care Physician _____

Address_____

Phone # _____

Referring Physician_____

Address_____

Phone # _____

INSURANCE INFORMATION

Primary Insurance _____**ID#**_____

Policy holder on card_____

Insurance mailing address_____

Customer service phone #_____

Secondary Insurance _____**ID#**_____

Policy holder on card_____

Patient Agreement and Authorization to Release Information:

I, the undersigned, realize that I am financially responsible for all services rendered to me by Women's Center for Pelvic Health (WCPH). For those insurances that WCPH accepts, I realize that I am personally responsible for all copayments, deductibles and non-covered services as dictated by my insurance coverage. I authorize WCPH to release to my insurance carrier any medical information necessary to obtain reimbursement. I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ **Date**_____

WOMEN'S CENTER FOR PELVIC HEALTH

Name: _____ Today's date: _____ Preferred language: _____
Date of birth: _____ Age: _____ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed
Ethnicity: ☐ Hispanic ☐ Non-Hispanic Race: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other/Multiple
Home phone: _____ Cell phone: _____

GYNECOLOGIC HISTORY

Have you had, or do you have:	YES	NO
Chronic pelvic pain	☐	☐
Endometriosis	☐	☐
Pelvic infections	☐	☐
Abnormal Pap smear	☐	☐
Infertility	☐	☐
Hysterectomy	☐	☐
If yes, removal of cervix?	☐	☐
Removal of tubes/ovaries	☐	☐

Other:

_____
_____
_____

MENSTRUAL HISTORY

Are you post-menopausal? ☐ Yes ☐ No
First day of last period: _____
Typical number of days of flow: _____
Typical number of days from first day of one period to first day of next period: _____
Do you have bleeding between periods? ☐ Yes ☐ No
Cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe
PMS: ☐ None ☐ Mild ☐ Moderate ☐ Severe

SEXUAL ACTIVITY

Are you sexually active? ☐ Yes ☐ No
Is/are your partner(s): ☐ Men ☐ Women ☐ Both
How many current partners do you have? _____
How many lifetime partners have you had? _____
Have you had a new partner in the last year? ☐ Yes ☐ No
Do you experience pain with sex? ☐ Yes ☐ No
Do you experience bleeding with sex? ☐ Yes ☐ No
Have you had possible contact with:
☐ HIV ☐ Hepatitis ☐ Chlamydia ☐ Gonorrhea
☐ Herpes ☐ Genital Warts/HPV ☐ Syphilis

CURRENT METHOD OF CONTRACEPTION

☐ IUD Type: _____
Date of insertion: _____

☐ Oral contraceptive
☐ Mini-pill/progestin-only pill
☐ Ortho Evra patch
☐ NuvaRing
☐ Depo Provera injection
☐ Nexplanon
☐ Natural family planning
☐ Not using contraception
☐ Condoms
☐ Spermicide
☐ Diaphragm
☐ Tubal ligation
☐ Essure
☐ Vasectomy

OTHER MEDICAL HISTORY

Have you had, or do you have:	YES	NO	Comments
Breast cancer	☐	☐	_____
Colon cancer	☐	☐	_____
Ovarian cancer	☐	☐	_____
Uterine cancer	☐	☐	_____
Other cancer	☐	☐	_____
Migraine headache	☐	☐	_____
Stroke	☐	☐	_____
Multiple sclerosis	☐	☐	_____
Seizures	☐	☐	_____
Glaucoma	☐	☐	_____
Hypertension	☐	☐	_____
Elevated cholesterol	☐	☐	_____
Heart murmur	☐	☐	_____
Heart attack	☐	☐	_____
Blood clotting disorder	☐	☐	_____
Anemia	☐	☐	_____
Blood transfusion	☐	☐	_____
Asthma	☐	☐	_____
Thyroid problems	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Chronic bronchitis	☐	☐	_____
Ulcer	☐	☐	_____
Irritable bowel syndrome	☐	☐	_____
Inflammatory bowel disease	☐	☐	_____
Gallstones	☐	☐	_____
Liver disease	☐	☐	_____
Kidney disease	☐	☐	_____
Chronic urinary tract infection	☐	☐	_____
Arthritis	☐	☐	_____
Autoimmune disorder	☐	☐	_____
Osteoporosis	☐	☐	_____
Stress/anxiety	☐	☐	_____
Depression	☐	☐	_____
Eating disorder	☐	☐	_____
Chemical dependency	☐	☐	_____
Other (please specify)	☐	☐	_____

PAST SURGERIES OR PROCEDURES

Date:	Procedure:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Primary concern to discuss today: _____

Other concerns to discuss if time allows: _____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

Please check all that apply.

- ☐ Weight loss
- ☐ Weight gain
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Fatigue
- ☐ Fevers/chills

- ☐ Headaches
- ☐ Vision problems
- ☐ Hearing problems

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Persistent cough

- ☐ Breast lumps
- ☐ Breast discharge
- ☐ Breast pain

- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Straining during bowel movement
- ☐ Bloody stool
- ☐ Fecal incontinence
- ☐ Bloating/gas
- ☐ Abdominal pain

- ☐ Urinary leakage
- ☐ Urinary urgency
- ☐ Urinary frequency
- ☐ Urinary pain
- ☐ Getting up >1 time at night to void
- ☐ Weak urine stream
- ☐ Difficulty voiding
- ☐ Incomplete bladder emptying
- ☐ Blood in urine

- ☐ Other: _____

- ☐ Skin rash
- ☐ Hair loss

- ☐ Depression
- ☐ Stress/anxiety

- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Areas of numbness/tingling
- ☐ Back pain

- ☐ Swollen lymph nodes
- ☐ Unexplained bruising/bleeding

- ☐ Vaginal dryness
- ☐ Bulge from vagina
- ☐ Loss of sexual drive

LIST ALL CURRENT MEDICATIONS, INCLUDING PRESCRIBED, OVER-THE-COUNTER, VITAMINS, AND HERBAL SUPPLEMENTS

Medication:	Dose:	Frequency:

DRUG ALLERGIES/SENSITIVITIES

Drug:	Reaction:

Are you allergic to latex? ☐ Yes ☐ No

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PREGNANCIES AND OUTCOMES

Please list all pregnancies in the space provided.

Date:	Type:	Weeks at delivery:	Sex:	Complications (if any):
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______
______	☐ Vaginal ☐ C-section ☐ Miscarriage ☐ Abortion ☐ Other	______	☐ F ☐ M	______

How many *living* children do you have? ______

HABITS & SOCIAL HISTORY

Do you / have you:	YES	NO	If yes, how much?
Smoke?	☐	☐	______
Consume alcohol?	☐	☐	______
Use illicit drugs?	☐	☐	______
Exercise?	☐	☐	______

Type of exercise: ______

Work description: ______

Who do you live with? ______

Have you experienced any changes at home? ☐ Yes ☐ No

If yes, please describe: ______

Have you experienced any form of abuse (physical, emotional, sexual)?

______

IMMUNIZATIONS & SCREENING

Have you had:	YES	NO	Year
HPV/Gardasil	☐	☐	______
Hepatitis B	☐	☐	______
Tetanus (within last 10 yrs)	☐	☐	______
Pneumococcal	☐	☐	______
Influenza (this season)	☐	☐	______
Mammogram	☐	☐	______
Colonoscopy	☐	☐	______
DEXA scan	☐	☐	______
Cholesterol testing	☐	☐	______
Diabetes testing	☐	☐	______
Thyroid testing	☐	☐	______

SAFETY

	YES	NO	NOT APPLICABLE
Do you wear a seatbelt every time you are in a car?	☐	☐	☐
Do you abstain from text messaging while driving?	☐	☐	☐
Do you wear a helmet when cycling/skating?	☐	☐	☐
If you have guns in your home, are they kept locked?	☐	☐	☐
Do you use a night light and keep floors clear to prevent falls?	☐	☐	☐

FAMILY HISTORY

Do you have a family history of:	YES	NO	Relationship of family member (e.g. maternal grandmother, paternal aunt)	Age when diagnosed	Is this person Living	Deceased	Age
Breast cancer	☐	☐	______	______	☐	☐	______
Colon cancer	☐	☐	______	______	☐	☐	______
Ovarian cancer	☐	☐	______	______	☐	☐	______
Uterine cancer	☐	☐	______	______	☐	☐	______
Other cancer	☐	☐	______	______	☐	☐	______
Osteoporosis	☐	☐	______	______	☐	☐	______
Hypertension	☐	☐	______	______	☐	☐	______
High cholesterol	☐	☐	______	______	☐	☐	______
Heart disease	☐	☐	______	______	☐	☐	______
Stroke	☐	☐	______	______	☐	☐	______
Blood clots	☐	☐	______	______	☐	☐	______
Diabetes	☐	☐	______	______	☐	☐	______
Thyroid disease	☐	☐	______	______	☐	☐	______
Autoimmune disease	☐	☐	______	______	☐	☐	______
Alcohol or drug abuse	☐	☐	______	______	☐	☐	______
Depression	☐	☐	______	______	☐	☐	______
Other mental illness	☐	☐	______	______	☐	☐	______
Other medical illness	☐	☐	______	______	☐	☐	______

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Basic personal information

1. Name _____ 2. Age _____ 3. Date _____

4. Education (the highest level you completed)

❑ Elementary ❑High school ❑ Technical or trade school ❑ Associate degree ❑ Bachelors degree

❑ Masters degree ❑ Doctorate ❑ Other _____

Information about your occupation and employment status

5. Which of the following best describes your current job status?

❑Employed ❑Self-employed ❑Homemaker ❑Unemployed ❑Disabled ❑Retired

	Yes	No
6. If you are disabled, is it because of pelvic pain?	O	O
7. Due to pelvic pain have you changed your work?	O	O
a. Changed to a less strenuous but full-time job	O	O
b. Changed to part-time work	O	O
c. Unable to work	O	O

8. If disabled or unable to work, how long have you been unable to work? _____

Information about the onset of your pain

9. Your age when you ***first*** started having pelvic pain: _____

10. If your pain had improved or gone away and now has returned, at about what age did it return? ____

10a. How many months have you had your current pain? _____

11. Please tell us how the pain started or the circumstances related to its onset:

_____

_____

_____

_____

_____

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Information about the nature & severity of your pain

12. How has the intensity of your pain changed over the past several months?

❑Increased ❑Decreased ❑Stayed the same ❑Varied

13. Which word or words would you use to describe the pattern of your pain? (mark all that apply)

(a)	(b)	(c)
❑ Continuous	❑ Rhythmic	❑ Brief
❑ Steady	❑ Periodic	❑ Momentary
❑ Constant	❑ Intermittent	❑ Transient

14. Please mark in the circle of the number that most appropriately rates your pain level:

(Use this rating scale: "0" equals *No pain* and "10" equals *Worst Possible Pain)*

	0	1	2	3	4	5	6	7	8	9	10
a. At its *worst* in the past month	O	O	O	O	O	O	O	O	O	O	O
b. At its *least* in the past month	O	O	O	O	O	O	O	O	O	O	O
c. At its *average* in the past month	O	O	O	O	O	O	O	O	O	O	O
d. At *mid-cycle* (ovulation)	O	O	O	O	O	O	O	O	O	O	O
e. *Before* period or menses	O	O	O	O	O	O	O	O	O	O	O
f. *With* period or menses	O	O	O	O	O	O	O	O	O	O	O
g. Level of *cramps* with *period or menses*	O	O	O	O	O	O	O	O	O	O	O
h. With *intercourse*	O	O	O	O	O	O	O	O	O	O	O
i. With a *full bladder*	O	O	O	O	O	O	O	O	O	O	O
j. With the need have a *bowel movement*	O	O	O	O	O	O	O	O	O	O	O
k. What would be an *acceptable* level of pain?	O	O	O	O	O	O	O	O	O	O	O

Information about the effect of pain on your daily life

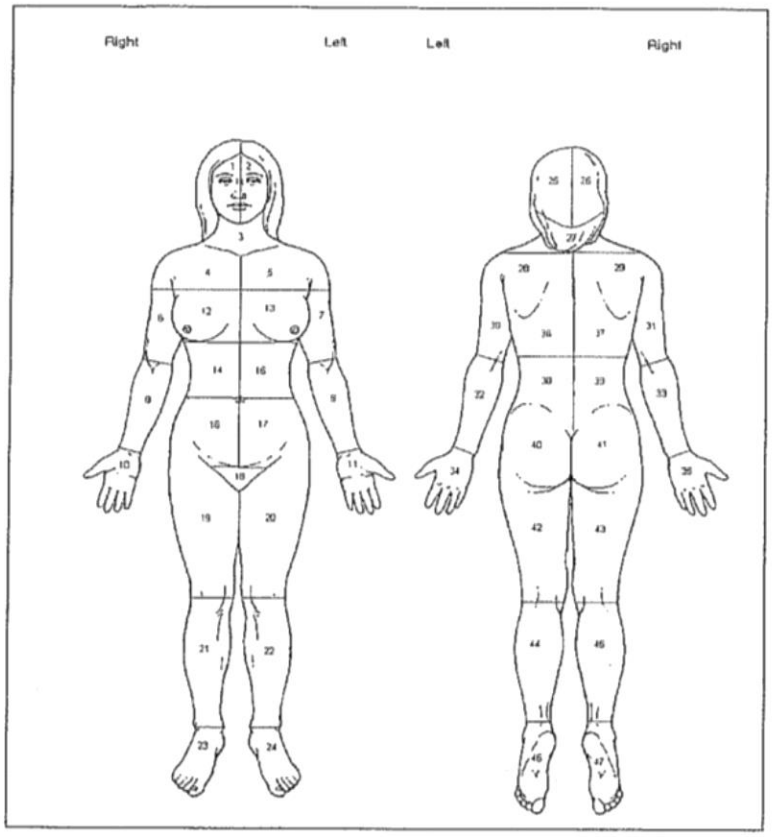
15. Please circle the one number that describes how, during the past month, pain has interfered with:

(*Use* this rating scale: *"0" if pain did not interfere at all and "10" if pain completely interfered)*

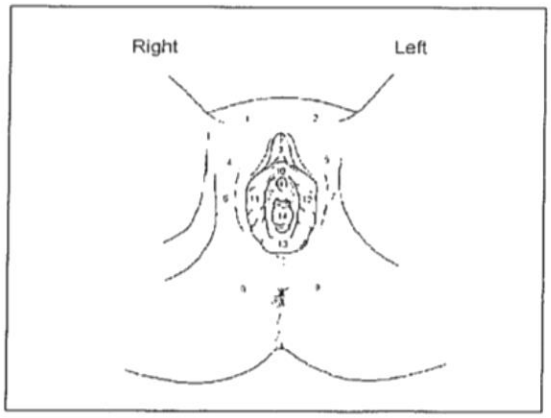
	0	1	2	3	4	5	6	7	8	9	10
a. General Activity	O	O	O	O	O	O	O	O	O	O	O
b. *Normal Work (includes housework)*	O	O	O	O	O	O	O	O	O	O	O
c. Walking Ability	O	O	O	O	O	O	O	O	O	O	O
d. Sleep	O	O	O	O	O	O	O	O	O	O	O
e. *Enjoyment of Life*	O	O	O	O	O	O	O	O	O	O	O
f. Mood	O	O	O	O	O	O	O	O	O	O	O
g. Relations with other people	O	O	O	O	O	O	O	O	O	O	O
h. Ability to have sexual relations	O	O	O	O	O	O	O	O	O	O	O

Information about the location of your pain.

16. On the diagram, shade in <u>all</u> the areas where you feel pain. If there is an area that hurts more than anywhere else, put an X on that area.



17. If you have pain on the vulva or perineum, shade in the areas on the diagram where you feel pain. If there is an area that hurts more than anywhere else, put an X on that area.



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Information about the characteristics of your pain

18. The words below can be used to describe pain. Please mark in the circle in the column that represents the degree or severity with which you feel that type of pain. For these questions, please limit yourself to a description of the pain in your pelvic area only.

Type of Pain	None (0)	Mild (1)	Moderate (2)	Severe (3)
a. Throbbing	O	O	O	O
b. Shooting	O	O	O	O
c. Stabbing	O	O	O	O
d. Sharp	O	O	O	O
e. Cramping	O	O	O	O
f. Gnawing	O	O	O	O
g. Hot-Burning	O	O	O	O
h. Aching	O	O	O	O
i. Heavy	O	O	O	O
j. Tender	O	O	O	O
k. Splitting	O	O	O	O
l. Tiring-Exhausting	O	O	O	O
m. Sickening	O	O	O	O
n. Fearful	O	O	O	O
o. Punishing-Cruel	O	O	O	O

20 [*Office use*

Information about your pain and overall general health

Please reflect on your sense of well-being over the past month, taking into account your physical, mental, emotional, social, and spiritual condition.

19. Mark the number that summarizes your overall sense of well-being for the past month.
(Use this rating scale: "0" for the *Worst you have ever been* and "10" for the *Best you have ever been*)

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

20. In general, would you say your health is:

❑Excellent ❑Very good ❑Good ❑Fair ❑Poor

21. When you feel pain (may mark as many as apply):
- ❑ It is terrible, and you feel it's never going to get any better.
- ❑ It is awful, and you feel that it overwhelms you.
- ❑ Your feel your life isn't worth living.
- ❑ You worry all the time about whether it will end.
- ❑ You feel you can't stand it anymore.
- ❑ You feel like you can't go on.
- ❑ None of the phrases above apply to you.

23 [*Office use*

Information about things that make your pain better or worse

22. What kinds of things decrease your pain? _____

23. What kinds of things increase your pain? _____

24. Is your pain *increased* by or at:

	Yes	No
a. Menses	O	O
b. Ovulation (mid-cycle)	O	O
c. Week before menses	O	O
d. Week after menses	O	O
e. Intercourse	O	O
f. Sitting	O	O
g. Standing	O	O
h. Full bladder	O	O
i. Emptying your bladder	O	O
j. Need to have a bowel movement	O	O
k. Having a bowel movement	O	O

25. Is your pain *decreased* by or at:

	Yes	No
a. Menses	O	O
b. Ovulation	O	O
c. Before menses	O	O
d. After menses	O	O
e. Lying down	O	O
f. Rest or sleep	O	O
g. Heating pad or hot pack	O	O
h. Hot bath	O	O
i. Cold compresses or ice packs	O	O
j. Emptying your bladder	O	O
k. Having a bowel movement	O	O
l. Pain medications	O	O

Information about medications you have taken for pain

Please list all medications that you have taken *for pain* (use separate page if needed)

26. Medication/Dose	Did it help?		
	❑Yes	❑No	❑Currently taking
	❑Yes	❑No	❑Currently taking
	❑Yes	❑No	❑Currently taking
	❑Yes	❑No	❑Currently taking
	❑Yes	❑No	❑Currently taking
	❑Yes	❑No	❑Currently taking

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Information about prior surgical treatments for pelvic pain

Yes No

27. Have you had surgery for pelvic pain? _____ O ___O

If yes,

a. How many laparoscopies have you had for pelvic pain? ____

b. How many laparotomies (big incisions) have you had for pelvic pain ? ____

28. If you had surgery for pain, did it help your pain? _____ O ___O

a. If surgery helped your pain, for how long did it help? _____

29. Please list your surgeries related to pain (use separate page if needed):

Year	Procedure	Surgeon	Diagnosis

Information about bowel or intestinal function and your pain

In the past 3 months have you had at least 3 days when you have had abdominal pain or discomfort that:

Yes No

30. Was relieved with a bowel movement? _____ O __O

31. Started with a change in how often you were having bowel movements? _____ O __O

32. Started with a change in the form or the appearance of stool or bowel movements? _____ O __O

34.1. *Office use*

33. In the past 3 months you have any of the following symptoms? Yes No

a. Less than 3 bowel movements per *week* _____ O __O

b. More than 3 bowel movements per *day* _____ O __O

c. Hard or lumpy stools _____ O __O

d. Loose or watery stools _____ O __O

e. Straining during a bowel movement _____ O __O

f. Urgent need to have a bowel movement _____ O __O

g. Feeling of incomplete emptying with bowel movements _____ O __O

h. Passing mucus at the time of bowel movements _____ O __O

i. Abdominal fullness, bloating, or swelling _____ O __O

j. Pain with bowel movements _____ O __O

35.1. *Office use*

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Information about bladder function and pain.

The following questions help diagnose interstitial cystitis, a disease that affects urinary function in addition to causing pelvic pain. Please mark the answer that best describes your bladder function and symptoms.

34. How often have you felt the strong need to urinate with little or warning?
❑ Not at all (0) ❑ Less than 1 time in 5 (1) ❑ Less than half the time (2)
❑ About half the time (3) ❑ More than half the time (4) ❑ Almost always (5)

35. Have you had to urinate less than two hours after you finished urinating?
❑ Not at all (0) ❑ Less than 1 time in 5 (1) ❑ Less than half the time (2)
❑ About half the time (3) ❑ More than half the time (4) ❑ Almost always (5)

36. How often do you most typically get up at night to urinate?
❑ None (0) ❑ Once (1) ❑ 2 times (2)
❑ 3 times (3) ❑ 4 times (4) ❑ 5 or more times (5)

37. Have you experienced pain or burning in your bladder?
❑ Not at all (0) ❑ A few times (2)
❑ Almost always (3) ❑ Fairly often (4) ❑ Usually (5)

39.1. *Office use*

38. How much has frequent urination during the day been a problem for you?
❑ No problem (0) ❑ Very small problem (1) ❑ Small problem (2)
❑ Medium problem (3) ❑ Big problem (4)

39. How much has getting up at night to urinate been a problem for you?
❑ No problem(0) ❑ Very small problem (1) ❑ Small problem (2)
❑ Medium problem (3) ❑ Big problem (4)

40. How much has the need to urinate with little warning been a problem for you?
❑ No problem (0) ❑ Very small problem (1) ❑ Small problem (2)
❑ Medium problem (3) ❑ Big problem (4)

41. How much has burning, pain, discomfort, or pressure in your bladder been a problem for you?
❑ No problem (0) ❑ Very small problem (1) ❑ Small problem (2)
❑ Medium problem (3) ❑ Big problem (4)

43.1. *Office use*

42. How many times do you go to the bathroom during the day to void or empty your bladder?
❑ 3-6 (0) ❑ 7-10 (1) ❑ 11-14 (2)
❑ 15-19 (3) ❑ 20 or more (4)

43.Do you involuntarily lose urine on a regular basis?
❑ No (0) ❑ Less than once a day (1) ❑ 1-3 times per day (2)
❑ 4-6 times per day (3) ❑ More than 6 times per day (4)

44. Please estimate the amount of liquids that you drink each day.
❑ Less than 8 ounces (0) ❑ 8-16 ounces (1) ❑ 17-32 ounces (2)
❑ 33-48 ounces (3) ❑ More than 48 ounces (4)

45. How many bladder infections or UTIs have you had in the past 12 months?
❑ None (0) ❑ One (1) ❑ Two (2)
❑ Three (3) ❑ Four or more (4)

WOMEN'S CENTER FOR PELVIC HEALTH

Information about possible depression

46. Please mark the response that comes closest to how you have been feeling lately.

a. I have been able to laugh and see the funny side of things
- ❑ As much as I always could (0)
- ❑ Not quite so much now (1)
- ❑ Definitely not so much now (2)
- ❑ Not at all (3)

b. I have looked forward with enjoyment to things
- ❑ As much as I ever did (0)
- ❑ I Rather less than I used to (1)
- ❑ Definitely less than I used to (2)
- ❑ Hardly at all (3)

c. I have blamed myself unnecessarily when things went wrong
- ❑ Yes, most of the time (3)
- ❑ Yes, some of the time (2)
- ❑ Not very often (1)
- ❑ No, never (0)

d. I have been anxious or worried for no good reason
- ❑ No, not at all (0)
- ❑ Hardly ever (1)
- ❑ Yes, sometimes (2)
- ❑ Yes, very often (3)

e. I have felt insecure or panicky for no very good reason
- ❑ Yes, quite a lot (3)
- ❑ Yes, sometimes (2)
- ❑ No, not much (1)
- ❑ No, not at all (0)

f. Things have been getting on top of me
- ❑ Yes, most of the time I haven't been able to cope at all (3)
- ❑ Yes, sometimes I haven't been coping as well as usual (2)
- ❑ No, most of the time I have coped quite well (1)
- ❑ No, I have been coping as well as ever (0)

g. I have been so unhappy that I have had difficulty sleeping
- ❑ Yes, most of the time (3)
- ❑ Yes, sometimes (2)
- ❑ Not very often (1)
- ❑ No, not at all (0)

h. I have felt sad or miserable
- ❑ Yes, most of the time (3)
- ❑ Yes, quite often (2)
- ❑ Not very often (1)
- ❑ No, not at all (0)

i. I have been so unhappy that I have been crying
- ❑ Yes, most of the time (3)
- ❑ Yes, quite often (2)
- ❑ Only occasionally (1)
- ❑ No, never (0)

j. The thought of harming myself has occurred to me
- ❑ Yes, quite often (3)
- ❑ Sometimes (2)
- ❑ Hardly ever (1)
- ❑ Never (0)

48 I. *Office use*

k. Of all the problems or stresses in your life, how does pain compare in importance?
- ❑ The most important problem (1)
- ❑ Just one of many problems (0)

WOMEN'S CENTER FOR PELVIC HEALTH

Information about any history of abuse.

We now know that many people have unwanted "sexual" or violent experiences as children or adults. Some of these are with playmates or friends and some with relatives or acquaintances. These experiences may be so upsetting that they may not be discussed with anyone. Sometimes they are forgotten for long periods of time, and sometimes they are frequently brought to mind. We would like you to help us understand these experiences. Please try to remember whether any of the following occurred to you:

	47. As a child (13 and younger)		48. As an adult (14 and over)	
	Yes	No	Yes	No
a. Has anyone ever exposed the sex organs of their body to you when you did not want it?	O	O	O	O
b. Has anyone ever threatened to have sex with you when you did not want it?	O	O	O	O
c. Has anyone ever touched the sex organs of your body when you did not want this?	O	O	O	O
d. Has anyone ever made you touch the sex organs of their body when you did not want this?	O	O	O	O
e. Has anyone ever forced you to have sex when you did not want this?	O	O	O	O
f. Have you had any other unwanted sexual experiences not mentioned above?	O	O	O	O

If so, please specify: _____

49. When you were a child (13 or younger), did an older person do the following:

	Never	Seldom	Occasionally	Often
a. Hit, kick, or beat you?	O	O	O	O
b. Seriously threaten your life?	O	O	O	O

50. Now that you are an adult (14 or older), has any other adult done the following:

	Never	Seldom	Occasionally	Often
a. Hit, kick, or beat you?	O	O	O	O
b. Seriously threaten your life?	O	O	O	O

Information about possible pelvic congestion syndrome

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

WOMEN'S CENTER FOR PELVIC HEALTH

Information about pain-related family history

57. Who in your family has or had:

- ❑ Endometriosis_____
- ❑ Fibromyalgia_____
- ❑ Depression_____
- ❑ Interstitial cystitis_____
- ❑ Irritable bowel syndrome_____
- ❑ Chronic pelvic pain_____

Information About Your Obstetrical History

	Yes	No
58. Were there any complications during pregnancy, labor, delivery, or post partum?	O	O
59. Did you have a 4° Episiotomy or laceration with any deliveries?	O	O
60. Did you have any vacuum deliveries?	O	O
61. Did have any forceps deliveries?	O	O
62. Did you have pelvic pain during any of your pregnancies?	O	O

Information About Your Health Habits

63. Have you had major accidents such as falls or a back injury? ☐ Yes ☐ No

64. What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)?
❑ 0 ❑ 1-3 ❑ 4-6 ❑ >6

65. Are you on a special diet? (check all that apply)
❑ No, regular, well balanced diet (a)
❑ Yes: Vegan (b) ❑ Vegetarian (c) ❑ Gluten-free (d) ❑ Lactose-free (e)
❑Other (f) _____

66. What do you think is causing your pain?_____

67. Do you think that your pain is due to something different than doctors have told you? No__ Yes__

68. Please tell us anything else we need to know about your pain (use separate page if needed)?

_____

_____

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