Pelvic Pain Assessment Form

Physician: _____________________________  Date: _____________________________

Initial History and Physical Examination            Date: _____________________________

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  -  n o  p a i n          10  –  t h e  w o r s t  p a i n  i m a g i n a b l e

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

Provider Comments
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

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**Information About Your Pain**

What types of treatments/providers have you tried in the past for your pain? Please check all that apply.

- Acupuncture
- Anesthesiologist
- Anti-seizure medications
- Antidepressants
- Biofeedback
- Botox injection
- Contraceptive pills/patch/ring
- Danazol (Danocrine)
- Depo-provera
- Gastroenterologist
- Gynecologist
- Family Practitioner
- Herbal Medicine
- Homeopathic medicine
- Lupron, Synarel, Zoladex
- Massage
- Meditation
- Narcotics
- Naturopathic medication
- Nerve blocks
- Neurosurgeon
- Nonprescription medicine
- Nutrition/diet
- Physical Therapy
- Psychotherapy
- Psychiatrist
- Rheumatologist
- Skin magnets
- Surgery
- TENS unit
- Trigger point injections
- Urologist
- Other

**Pain Maps**

Please shade areas of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)

![Vulvar / Perineal Pain Diagram](image)

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10 = most severe pain imaginable)

Is your pain relieved by sitting on a commode seat? □ Yes □ No

Right  □ Yes  □ No

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

<table>
<thead>
<tr>
<th>Physician / Provider</th>
<th>Specialty</th>
<th>City, State, Phone</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**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**:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
<th>Surgeon</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Please list all **other** surgical procedures:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
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<tbody>
<tr>
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**Provider Comments**

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

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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):

<table>
<thead>
<tr>
<th>Medication / dose</th>
<th>Provider</th>
<th>Did it help?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
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<td>☐ Yes ☐ No ☐ Currently taking</td>
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<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No ☐ Currently taking</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication / dose</th>
<th>Provider</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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 _________________

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### 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
  - Are periods regular? □ Yes □ No
  - Pain starts ______ days before flow
- 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
  - □ 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.

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many times do you go to the bathroom <strong>DURING THE DAY</strong> (to void or empty your bladder)?</td>
<td>3-6</td>
<td>7-10</td>
<td>11-14</td>
<td>15-19</td>
<td>20 or more</td>
</tr>
<tr>
<td>2. How many times do you go to the bathroom <strong>AT NIGHT</strong> (to void or empty your bladder)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4 or more</td>
</tr>
<tr>
<td>3. If you get up at night to void or empty your bladder does it bother you?</td>
<td>Never</td>
<td>Mildly</td>
<td>Moderately</td>
<td>Severely</td>
<td></td>
</tr>
<tr>
<td>4. Are you sexually active? □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>6. If you have pain with intercourse, does it make you avoid sexual intercourse?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>8. Do you have urgency after voiding?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>9. If you have pain, is it usually</td>
<td>Never</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>10. Does your pain bother you?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>11. If you have urgency, is it usually</td>
<td></td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>12. Does your urgency bother you?</td>
<td>Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td></td>
</tr>
</tbody>
</table>

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KCI ____ Not Indicated     ____ Positive     ____ Negative

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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

Check an answer for both as a child and as an adult.

As a child (13 and younger) As an adult (14 and over)
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 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? ☐ Yes ☐ No ☐ Yes ☐ No

If yes, please specify _______________________________________________________________________________

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

**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?

<table>
<thead>
<tr>
<th>Type</th>
<th>None (0)</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throbbing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shooting</td>
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<tr>
<td>Stabbing</td>
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<tr>
<td>Sharp</td>
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<tr>
<td>Cramping</td>
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<tr>
<td>Gnawing</td>
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<tr>
<td>Hot-Burning</td>
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<tr>
<td>Aching</td>
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<tr>
<td>Heavy</td>
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<tr>
<td>Tender</td>
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<tr>
<td>Splitting</td>
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<tr>
<td>Tiring-Exhausting</td>
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<td></td>
</tr>
<tr>
<td>Sickening</td>
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</tr>
<tr>
<td>Fearful</td>
<td></td>
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<tr>
<td>Punishing-Cruel</td>
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**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