

Pelvic Pain Assessment Form

Physician: _____

Date: _____

Initial History and Physical Examination

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 - no pain 10 - the worst pain imaginable

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

Provider Comments

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

<i>Physician / Provider</i>	<i>Specialty</i>	<i>City, State, Phone</i>

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**:

Year	Procedure	Surgeon	Findings

Please list all **other** surgical procedures:

Year	Procedure

Year	Procedure

Provider Comments

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):

Medication / dose	Provider	Did it help?
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently taking

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

Medication / dose	Provider	Medical Condition

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 _____

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 Pain starts _____ days before flow

Are periods regular? Yes No

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

What is your use of recreational drugs? Never used Used in the past, but not now Presently using No answer

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.

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

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KCl ____ Not Indicated ____ Positive ____ Negative

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

- | | As a child
(13 and younger) | As an adult
(14 and over) |
|---|--|--|
| Check 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1b. Has anyone ever threatened to have sex with you when you did not want it? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1c. Has anyone ever touched the sex organs of your body when you did not want this? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1d. Has anyone ever made you touch the sex organs of their body when you did not want this? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1e. Has anyone forced you to have sex when you did not want this? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1f. Have you had any other unwanted sexual experiences not mentioned above? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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

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 1995;21:141-148.

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?

<i>Type</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Gnawing	_____	_____	_____	_____
Hot-Burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring-Exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Punishing-Cruel	_____	_____	_____	_____

Melzak R. The Short-form McGill Pain Questionnaire. Pain 1987;30:191-197.

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

Physical Examination – For Physician Use Only

Name: _____ Chart Number: _____

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____

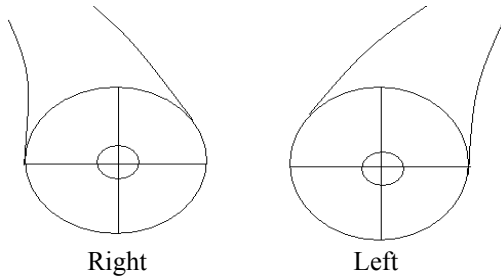
BP: _____ HR: _____ Temp: _____ Resp: _____ LMP: _____

ROS, PFSH Reviewed: Yes No Physician Signature: _____

General Appearance: Well-appearing Ill-appearing Tearful Depressed
 Normal weight Underweight Overweight Abnormal Gait

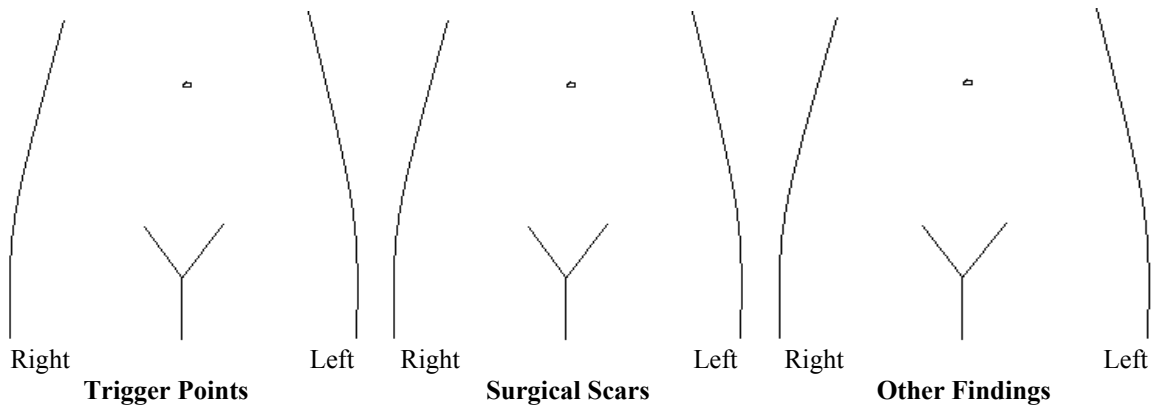
NOTE: Mark "Not Examined" as N/E

HEENT WNL Other _____ Lungs WNL Other _____ Heart WNL Other _____ Breasts WNL Other _____



Abdomen

Non-tender Tender Incisions Trigger Points
 Inguinal Tenderness Inguinal Bulge Suprapubic Tenderness Ovarian Point Tenderness
 Mass Guarding Rebound Distention
 Other _____

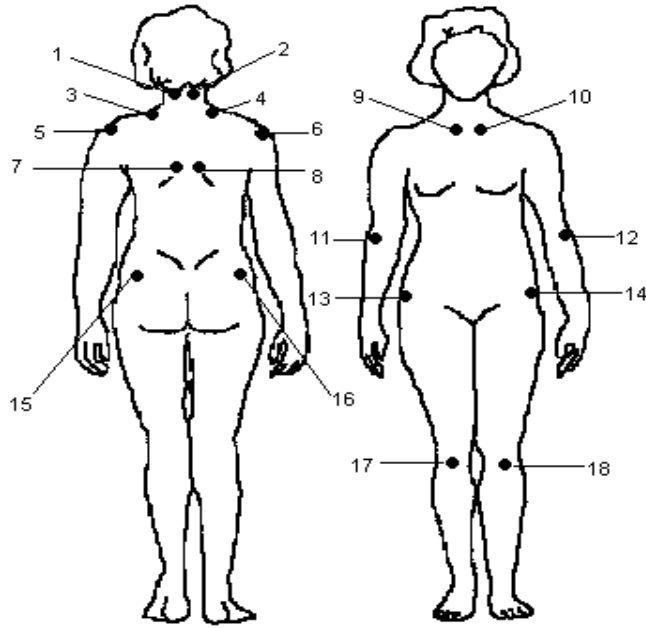


Back Non-tender Tender Alteration in posture SI joint rotation _____

Lower Extremities WNL Edema Varicosities Neuropathy Length Discrepancy _____

Neuropathy Iliohypogastric Ilioinguinal Genitofemoral Pudendal Altered sensation

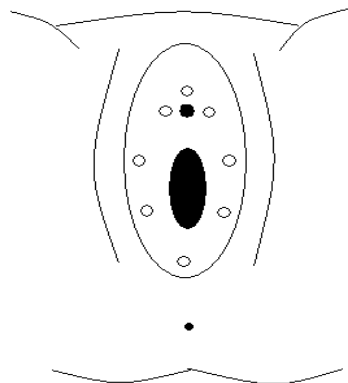
Fibromyalgia / Back / Buttock



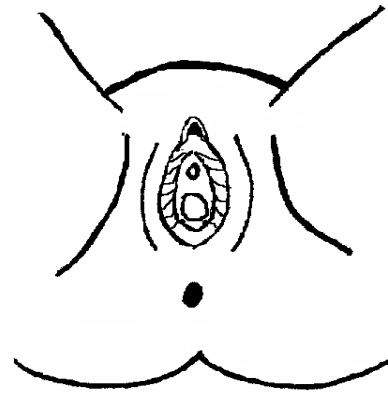
Left Right Right Left

External Genitalia

- WNL Erythema Discharge Q-tip test (show on diagram) Tenderness (show on diagram)



Right Left



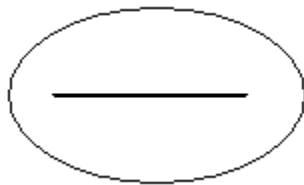
Right Left

Q-tip Test (score each circle 0-4) **Total Score** _____

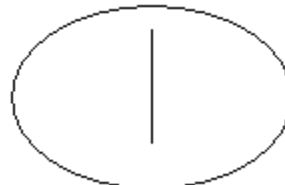
Other Findings _____

Vagina

- WNL Wet prep: _____
 Local tenderness _____ Vaginal mucosa _____ Discharge _____
 Cultures: GC Chlamydia Fungal Herpes
 Vaginal Apex Tenderness (post hysterectomy – show on diagram)



Right Left
Transverse apex closure



Vertical apex closure

Unimanual Exam

- | | |
|--|--|
| <input type="checkbox"/> WNL | <input type="checkbox"/> Cervix |
| <input type="checkbox"/> Introitus | <input type="checkbox"/> Cervical motion |
| <input type="checkbox"/> Uterine-cervical junction | <input type="checkbox"/> Parametrium |
| <input type="checkbox"/> Urethra | <input type="checkbox"/> Vaginal cuff |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Cul-de-sac |
| <input type="checkbox"/> R ureter | <input type="checkbox"/> L ureter |
| <input type="checkbox"/> R inguinal | <input type="checkbox"/> L inguinal |
| <input type="checkbox"/> Muscle awareness | <input type="checkbox"/> Clitoral tenderness |

Rank muscle tenderness on 0-4 scale

- | | |
|---|--|
| <input type="checkbox"/> R obturator _____ | <input type="checkbox"/> L obturator _____ |
| <input type="checkbox"/> R piriformis _____ | <input type="checkbox"/> L piriformis _____ |
| <input type="checkbox"/> R pubococcygeus _____ | <input type="checkbox"/> L pubococcygeus _____ |
| <input type="checkbox"/> Total pelvic floor score _____ | <input type="checkbox"/> Anal Sphincter _____ |

Bimanual Exam

- | | | | |
|--------------|---|--|--------------------------------------|
| Uterus: | <input type="checkbox"/> Tender | <input type="checkbox"/> Non-tender | <input type="checkbox"/> Absent |
| Position: | <input type="checkbox"/> Anterior | <input type="checkbox"/> Posterior | <input type="checkbox"/> Midplane |
| Size: | <input type="checkbox"/> Normal | <input type="checkbox"/> Other _____ | |
| Contour: | <input type="checkbox"/> Regular | <input type="checkbox"/> Irregular | <input type="checkbox"/> Other _____ |
| Consistency: | <input type="checkbox"/> Firm | <input type="checkbox"/> Soft | <input type="checkbox"/> Hard |
| Mobility: | <input type="checkbox"/> Mobile | <input type="checkbox"/> Hypermobility | <input type="checkbox"/> Fixed |
| Support: | <input type="checkbox"/> Well supported | <input type="checkbox"/> Prolapse | |

Adnexal Exam

- | | | | |
|--------------------------------|--|--------------------------------|--|
| Right: | <input type="checkbox"/> Absent | Left: | <input type="checkbox"/> Absent |
| <input type="checkbox"/> WNL | <input type="checkbox"/> Tender | <input type="checkbox"/> WNL | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Enlarged _____ cm | <input type="checkbox"/> Fixed | <input type="checkbox"/> Enlarged _____ cm |

Rectovaginal Exam

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> WNL | <input type="checkbox"/> Nodules | <input type="checkbox"/> Guaiac positive |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Mucosal pathology | <input type="checkbox"/> Not examined |

Assessment: _____

Diagnostic Plan: _____

Therapeutic Plan: _____
