

NY Pelvic Pain and Minimally Invasive Gynecologic Surgery, P.C.

DATE: _____

Please describe your pain problem: _____

What do you think is causing your pain? _____

Do you think anyone is to blame for your pain? Yes No If so, who? _____

Do you think surgery will be necessary? Yes No

Is there an event that you associate with the onset of pain? Yes No

If so, what? _____

How long have you had this pain? < 6 months 6 months – 1 year

1 – 2 years > 2 years

For each of the symptoms listed below, please “bubble in” your level of pain over the last month:

0 =no pain; 10= the worst pain imaginable

How do you rate your present 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 level 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) 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"/>
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"/>
Pain lasting hours or days 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 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"/>
Ovarian 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 <u>cramps</u> 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"/>
<u>Burning</u> vaginal pain with 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 bowel movements	<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"/>
How much pain is acceptable to you?	<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"/>

What is the worst type of pain that you have ever experienced?

Kidney stone Bowel obstruction Migraine headache Childbirth

Current pelvic pain Backache Broken bone Surgery Other

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
Bachelor's degree Postgraduate degree

What kind of work are you trained for? _____

What type of work are you doing? _____

Do you get regular exercise? Yes No Type: _____

What is your diet like? _____

What is your caffeine intake (number per day, include coffee, tea, soft drinks, etc.)?

0 1-3 4-6 >6

How many cigarettes do you smoke per day? _____ How many years? _____

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your drinking, or about something you said or did while you were drinking? Yes No

Have you ever taken a morning "eye-opener" drink? Yes No

What is your use of recreational drugs? Never used Used in past, but not now
Presently using Choose not to answer
Heroin Amphetamines Marijuana
Barbiturates Cocaine Other

Have you ever received treatment for substance abuse? Yes No

Who are the people you talk to concerning your pain, or during stressful times?

Spouse/Partner Relative Support Group Clergy Friend Doctor/Nurse
Mental Health Professional 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 of the problems or stresses in your life, how does your pain compare in importance?

The most important problem Just one of several/many problems

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? _____

Do you have any pain with your periods? Yes No

Do any pain medications help with pain during the menses? Yes No

Does pain start the day flow starts? Yes No

Starts days before flow starts: Yes No

Are periods regular? Yes No

Do you pass any clots in menstrual flow? Yes No

Have you ever had a sexually transmitted disease? (Chlamydia, gonorrhea, herpes, syphilis, HIV, trichomonas) Yes No

Do you have frequent yeast infections? Yes No

Birth control method: Nothing Pill Vasectomy Hysterectomy

IUD Rhythm Diaphragm Tubal Ligation Condom Other:

Is future fertility desired? Yes No

How many pregnancies have you had?

Resulting in (#): Full term (9 month) _____

Premature _____

Abortions (miscarriage) _____

living children _____

Any complications during pregnancy, labor, delivery, or post partum period?

4° Episiotomy C-section Post-partum bleeding Depression

Vaginal lacerations Forceps Other: _____

Do you experience any of the following?

Loss of urine when coughing, sneezing, or laughing? Yes No

Frequent urination? Yes No

Need to urinate with little warning? Yes No

Difficulty passing urine? Yes No

Frequent bladder infections? Yes No

Frequency of nighttime urination: 0-1 2 or more

Frequency of daytime urination: 8 or less 9-15 >16

Do you still feel full after urination? Yes No

In the past 6 months, have you had at least 3 months (not necessarily consecutively), of any of the following:

- Recurrent abdominal pain or discomfort that improved with defecation (bowel movement).
- Recurrent abdominal pain or discomfort that was associated with a change in the frequency of stool.
- Recurrent abdominal pain or discomfort that was associated with a change in form (appearance)

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

Which statement(s) below best describes how you cope with the pain?

Check all that apply

- I count numbers in my head or run a song through my mind
- I tell myself to be brave and carry on despite the pain
- I just think of it as some other sensation, such as numbness
- I tell myself that it really doesn't hurt
- I pray to God it won't last long I worry all the time about whether it will end
- I do something active, like household chores or projects
- I take pain medication I ignore it as best I can
- Other _____

What types of treatments have you tried in the past for this pain?

- Acupuncture Homeopathic medicine Physical therapy
- Lupron, Zoladex, Synarel Psychotherapy Anti-seizure medications Massage
- Antidepressants Meditation Skin magnets
- Biofeedback Narcotics Surgery Birth control pills Nutrition/diet
- Naturopathic medications TENS unit Nerve blocks Trigger point injections
- Depo-Provera Nonprescription medicine Herbal medication

Other _____

What physicians or health care providers have evaluated or treated you for chronic pelvic pain? Include all healthcare professionals, whether they were physicians or not. Do you give permission to Dr. Levey to contact these healthcare providers?

Yes Signature _____ No
Physician/Provider **Phone** **City, State**

Who is your primary care physician? _____

Please list all surgical procedures you've had (*related to this pain*):

<i>Year</i>	<i>Procedure</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all other surgical procedures:

<i>Year</i>	<i>Procedure</i>
_____	_____
_____	_____

Please list pain medications you've taken for your pain condition in the past 6 months, and the physicians who prescribed them (use separate page if necessary):

<i>Medication</i>	<i>Physician</i>	<i>Did it help?</i>	
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

Have you ever been hospitalized for anything besides surgery or childbirth?

Yes No If yes, explain: _____

Have you had major accidents such as falls or back injury? Yes No

Have you ever been treated for depression? Yes No

Treatments: Medication Hospitalization Psychotherapy

Have you ever been treated for any other psychiatric illness? Yes No

Treatments: Medication Hospitalization Psychotherapy

Has anyone in your family ever had: Fibromyalgia Chronic pelvic pain

Scleroderma Endometriosis Lupus Interstitial cystitis

Cancer Depression Irritable Bowel Syndrome

Recurrent Urinary Tract Infections Fibroids Adenomyosis

Rheumatoid arthritis Vulvodynia Schizophrenia Migraine headaches

What would you like to tell us about your pain that we have not asked? _____

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted. Yes No (As a child (13 and younger) or as an adult (14 and over)?)

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

Has anyone ever exposed the sex organs of their body to you when you did not want it? Child: Yes No Adult: Yes No

Has anyone ever threatened to have sex with you when you did not want it? Child: Yes No Adult: Yes No

Has anyone ever touched the sex organs of your body when you did not want this? Child: Yes No Adult: Yes No

Has anyone ever made you touch the sex organs of their body when you did not want this? Child: Yes No Adult: Yes No

Has anyone ever forced you to have sex when you did not want this? Child: Yes No Adult: Yes No

Have you had any other unwanted sexual experiences not mentioned above? If yes, please specify: _____

When you were a child (13 or younger), did an older person do the following? (Circle)

Hit, kick, or beat you? Never Seldom Occasionally Often

Threaten your life? Never Seldom Occasionally Often

Now that you are an adult (14 or older), has any other adult done the following? (Circle)

Hit, kick, or beat you? Never Seldom Occasionally Often

Seriously threaten your life? Never Seldom Occasionally Often

Please place an "X" at the point of your most intense pain.
Shade in all other painful areas.

BACK

FRONT

