Pelvic Pain Questionnaire

Te Whatu Ora
Health New Zealand

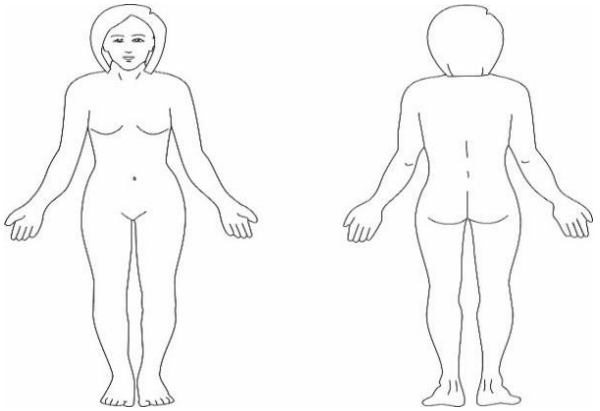
This questionnaire asks about different features of your pain and how it affects your life. It may seem a lot to fill in, but the information allows us more time in your appointment to focus on what troubles you the most.

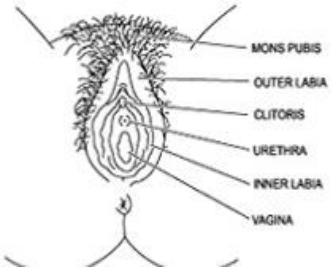
Read the questions carefully, but don't spend too long thinking about your answers. Your first answer is usually the best. There are no right or wrong answers. This is ***not*** a test of your medical knowledge.

If you find reading or writing difficult, please ask someone to help you fill it in. Make sure the answers are still your own and not those of the person helping you. It's your pain experience that we are interested in. If you need more space add another page.

Name:	**Date completed:** ……./……../20….	**NHI or DoB:**
Preferred name:	**What pronouns do you use?** She/Her He/Him Other: ____	
Who referred you here?	**GP:**	

1. **On the diagram below, shade *all* the areas where you often experience/have problems with pain.**





2. **Mark the worst pain with an 'X'. How long have you had this pain?** _____ weeks/months/years

3. **Overtime is this pain getting:** ☐ Better ☐ Worse ☐ No change/the same

4. **How long have you had problems with pain of any type** _____ weeks/months/years
(above what is normal)?

5. **Please describe your pain(s):** _____
_____

6. **What is your biggest concern/worry about your pain(s)?** _____

7. **What do you think is causing your pain(s)?** _____

8. **What treatment(s) do you think you need for your pain(s)?** _____
_____

9. **In an average month how many days would you have pain?** _____/30

In an average month how many days would you not have any pain? _____/30

10. **Please rate your pain – where 0 is no pain and 10 is the worst possible pain:**
Your pain at its *worst* in the last week? _____/10
Your pain at its *least* in the last week? _____/10
Your pain on *average*? _____/10
How much pain do you have right *now*? _____/10 ☐

Has your pain in the last week been: ☐ Typical for you ☐ Worse than usual ☐ Better than usual?

OTHER SYMPTOMS

11. **Do you also have/had any of these problems?**

☐ Vulval pain/vulvodynia ☐ Lower back pain ☐ Migraine headaches ☐ Other frequent headaches

☐ Fibromyalgia ☐ TMJ/facial pain ☐ Chronic fatigue/ME ☐ Irritable bowel syndrome (IBS)

☐ Bladder pain syndrome/ interstitial cystitis ☐ Restless legs syndrome ☐ Persisting pain problems in other parts of your body: Where? _____

12. **Please circle the best response to the right of each statement**.

I feel tired and unrefreshed when I wake from sleeping	never	rarely	sometimes	often	always
My muscles feel stiff and achy	never	rarely	sometimes	often	always
I have anxiety attacks	never	rarely	sometimes	often	always
I grind or clench my teeth	never	rarely	sometimes	often	always
I have problems with diarrhea and/or constipation	never	rarely	sometimes	often	always
I need help in performing my daily activities	never	rarely	sometimes	often	always
I am sensitive to bright lights	never	rarely	sometimes	often	always
I get tired very easily when I am physically active	never	rarely	sometimes	often	always
I feel pain all over my body	never	rarely	sometimes	often	always
I have headaches	never	rarely	sometimes	often	always
I feel discomfort in my bladder and/or burning when I urinate	never	rarely	sometimes	often	always
I do not sleep well	never	rarely	sometimes	often	always
I have difficulty concentrating	never	rarely	sometimes	often	always
I have skin problems such as dryness, itchiness, or rashes	never	rarely	sometimes	often	always
Stress makes my physical symptoms get worse	never	rarely	sometimes	often	always
I feel sad or depressed	never	rarely	sometimes	often	always
I have low energy	never	rarely	sometimes	often	always
I have muscle tension in my neck and shoulders	never	rarely	sometimes	often	always
I have pain in my jaw	never	rarely	sometimes	often	always
Certain smells, such as perfumes, make me feel dizzy and nauseated	never	rarely	sometimes	often	always
I have to urinate frequently	never	rarely	sometimes	often	always
My legs feel uncomfortable and restless when I am trying to go to sleep at night	never	rarely	sometimes	often	always
I have difficulty remembering things	never	rarely	sometimes	often	always
I suffered trauma as a child	never	rarely	sometimes	often	always
I have pain in my pelvic area	never	rarely	sometimes	often	always

PERIOD/MENSTRUAL

13. **Are you still having menstrual periods?** ☐ Yes ☐ No

If no, why is this? ☐ Have had a hysterectomy ☐ Menopause/change of life ☐ Taking pill/injection/IUD

☐ Other: _____

14. **Are/were your periods painful?** ☐ Yes ☐ No ☐ Sometimes

If yes, how old were you when they first became painful? _____ years old

15. **Does/did your pain vary through the cycle?** ☐ Yes ☐ No

If yes, is the pain worse: ☐ When I ovulate ☐ When my period/bleeding starts ☐ A few days before my bleeding
☐ Other: _____

16. **Are/were you able to use tampons comfortably?** ☐ Yes ☐ No ☐ Never use tampons for another reason

17. **Do you experience sharp stabbing pains that shoot up into your vagina or rectum?** ☐ Yes ☐ No ☐ Sometimes

BLADDER

18. **Please circle responses in table below**

	0	1	2	3	4
How many times do you urinate during the waking hours?	3-6	7-10	11-14	15-19	20 or more
How many times do you get out of bed to urinate?	0	1	2	3	4 or more
Do you now or have you ever had pain or urgency to urinate during or after sexual intercourse?	never	occasionally	usually	always	
Do you have pain associated with your bladder in your pelvis (vagina, lower abdomen, urethra, perineum)?	never	occasionally	usually	always	
Do you still have urgency (strong need to go again) shortly after urinating?	never	occasionally	usually	always	
If you have pain, is it usually:	none	mild	moderate	severe	
If you have urgency, is it usually	none	mild	moderate	severe	

19. **Have you noticed that when you pass urine the flow is slow to start, has a weak, stream, or you have to strain/push to pass urine?** ☐ Yes ☐ No ☐ Sometimes

20. **Do you have problems with holding on/leaking** ☐ Yes ☐ No ☐ Sometimes

BOWEL

21. **Are you happy with the way your bowel works?** ☐ Yes ☐ No ☐ Mostly

22. **Since you have had the pain have you noticed:**

A change in how often you have a bowel movement? ☐ Yes ☐ No

A change in the appearance of your stool/bowel movement? ☐ Yes ☐ No

Does your pain change after a bowel movement? ☐ Yes ☐ No

Do you notice that certain foods worsen your pain? ☐ Yes ☐ No ☐ Sometimes

Are you troubled with nausea or vomiting? ☐ Yes ☐ No ☐ Sometimes

Are you troubled with bloating? ☐ Yes ☐ No ☐ Sometimes

CONTRACEPTION/INTERCOURSE

23. **Are you trying to become pregnant at the moment?**

☐ Yes How long for? _____months/years

☐ No What do you use for contraception/birth control?

☐ Pill ☐ 'Mini Pill' ☐ Depo Provera/Injection ☐ Jadelle/Implant
☐ Condom ☐ Copper Iucd/'Coil' ☐ Mirena/Jaydess Iucd/Ius ☐ Hysterectomy
☐ Sterilisation/'Tube Tie' ☐ Vasectomy ☐ Other _____

24. **Does the contraceptive pill/injection/IUD help your period pain?**

☐ Yes, a little ☐ Yes, a lot ☐ No ☐ Not tried

25. **Are you sexually active?** ☐ Yes ☐ No – due to pain ☐ No – for another reason

26. **Have you experienced pain with intercourse?** ☐ Yes ☐ No ☐ Occasionally

If yes, do you feel this pain: ☐ Inside your abdomen/belly ☐ Inside your vagina ☐ Outside/on your vulva
☐ On penetration ☐ On orgasm ☐ Other area: _____

MEDICATIONS

27. **Do you have any allergies to any medications?** ☐ Yes ☐ No *If yes*, please list _____

28. **Please list medications you have *tried* for your pain, include ones prescribed by your doctor and ones bought at the pharmacy or elsewhere** *(use an extra page if needed)*

MEDICATION/DOSE	CURRENTLY TAKING	DID IT HELP
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

OTHER PRACTITIONERS CONSULTED

29. **Apart from your GP, who else have you seen for your pain(s)?**

☐ Public hospital gynaecologist ☐ Private gynaecologist ☐ Pain doctor/pain clinic ☐ Physiotherapist
☐ Chiropractor/osteopath ☐ Psychologist ☐ Sexual health clinic ☐ Other: _____

Please list names if you can: _____

_____

SURGERY

30. **Have you ever had any surgery to try to investigate or treat your pain(s)?**

☐ Yes ☐ No *If yes,* how many times: _____ __

What operation(s)? _____

How much did the surgery(ies) help your pain: ☐ A lot ☐ A little ☐ Not at all ☐ Made it worse

If it helped how long for? _____

Who/what was the surgeon/hospital? _____

Which year(s)? _____

SOCIAL

31. **With whom do you live?** ☐ Alone ☐ Partner ☐ Friends/flat mates ☐ Parents ☐ Other: _____

How do those who are close to you react when you are in pain? _____

32. **Overall, how would you describe your mood most of the time for the last 3 months?**

☐ Good ☐ Low/depressed ☐ Angry ☐ Anxious ☐ Other: _____

33. **Have you had any history of:** ☐ Depression ☐ Anxiety ☐ PTSD
☐ Other mental health condition: _____

34. **Do you have any other significant stress in your life at the moment?** ☐ Yes ☐ No

35. **Have you ever been the victim of physical or emotional abuse?** ☐ Yes ☐ No ☐ Prefer not to answer

36. **Have you had any unwanted sexual experiences?** ☐ Yes ☐ No ☐ Prefer not to answer

EFFECT ON YOUR LIFE

37. **What is your current work status?**

☐ Full time work ☐ Part time work ☐ Home duties/parenting ☐ Retired
☐ Student ☐ Reduced hours/duties due to pain ☐ Unemployed due to pain ☐ Other: _____

38. **How many times in the last 3 months have you had to do the following due to your pain?**

Visit your GP _____ Visit the after-hours clinic _____ Go to Emergency Dept _____
Be admitted to hospital _____ Have a sick day off work or school _____ Spend a day in bed _____

39. **During the past week, how much has pain interfered with the following?**

0 = *did not interfere* and 10 = *interfered completely*. Circle the number that best describes:

	Did not interfere										Interfered completely
Your general activity?	0	1	2	3	4	5	6	7	8	9	10
Your mood?	0	1	2	3	4	5	6	7	8	9	10
Your walking ability?	0	1	2	3	4	5	6	7	8	9	10
Your normal work (both outside the home and housework)?	0	1	2	3	4	5	6	7	8	9	10
Your relations with other people?	0	1	2	3	4	5	6	7	8	9	10
Your sleep?	0	1	2	3	4	5	6	7	8	9	10
Your enjoyment of life?	0	1	2	3	4	5	6	7	8	9	10

40. Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

When I'm in pain …	**Not at all 0**	**To a slight degree 1**	**To a moderate degree 2**	**To a great degree 3**	**All the time 4**
a) I worry all the time about whether the pain will end	☐	☐	☐	☐	☐
b) I feel I can't go on	☐	☐	☐	☐	☐
c) It's terrible and I think it's never going to get any better	☐	☐	☐	☐	☐
d) It's awful and I feel that it overwhelms me	☐	☐	☐	☐	☐
e) I feel I can't stand it anymore	☐	☐	☐	☐	☐
f) I become afraid that the pain will get worse	☐	☐	☐	☐	☐
g) I keep thinking of other painful events	☐	☐	☐	☐	☐
h) I anxiously want the pain to go away	☐	☐	☐	☐	☐
i) I can't seem to keep it out of my mind	☐	☐	☐	☐	☐
j) I keep thinking about how much it hurts	☐	☐	☐	☐	☐
k) I keep thinking about how badly I want the pain to stop	☐	☐	☐	☐	☐
l) There's nothing I can do to reduce the intensity of the pain	☐	☐	☐	☐	☐
m) I wonder whether something serious may happen	☐	☐	☐	☐	☐

41. **Is there anything else we should know about your pain or situation?** *(please add an extra page if needed)*

_____

_____

_____

_____