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)	○	○	○	○	○	○	○	○	○	○	○
Pain level just before period	○	○	○	○	○	○	○	○	○	○	○
Pain (not cramps) with period	○	○	○	○	○	○	○	○	○	○	○
Deep pain with intercourse	○	○	○	○	○	○	○	○	○	○	○
Pain in groin when lifting	○	○	○	○	○	○	○	○	○	○	○
Pain lasting hours or days after sex	○	○	○	○	○	○	○	○	○	○	○
Pain when bladder is full	○	○	○	○	○	○	○	○	○	○	○
Muscle/joint pain	○	○	○	○	○	○	○	○	○	○	○
Ovarian pain	○	○	○	○	○	○	○	○	○	○	○
Level of cramps with period	○	○	○	○	○	○	○	○	○	○	○
Pain after period is over	○	○	○	○	○	○	○	○	○	○	○
Burning vaginal pain with sex	○	○	○	○	○	○	○	○	○	○	○
Pain with urination	○	○	○	○	○	○	○	○	○	○	○
Backache	○	○	○	○	○	○	○	○	○	○	○
Migraine headache	○	○	○	○	○	○	○	○	○	○	○
Pain with bowel movements	○	○	○	○	○	○	○	○	○	○	○
How much pain is acceptable to you?	○	○	○	○	○	○	○	○	○	○	○

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?
❑4º 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***):

Year ***Procedure*** ***Surgeon***

_____
_____
_____
_____

Please list all other surgical procedures:

Year ***Procedure***

_____
_____
_____

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):

Medication ***Physician*** ***Did it help?***

_____ 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*