Please complete the following form PRIOR to your visit at the pain clinic. The form is long, but we appreciate your time and ask you to complete this form because it will help us provide you with better care. Your provider will review the form at your visit.

Please all have a look at our resources page prior to your visit: http://lowellpaincenter.com/pelvic-pain/

Pelvic Medical History

Have you been diagnosed with any of the following conditions?

☐ Endometriosis	☐ Interstitial cystitis	☐ Chronic prostatitis	☐ Fibromyalgia	☐ Chronic fatigue
☐ Depression	☐ Anxiety	☐ Migraine	☐ Cancer	☐ Irritable bowel syndrome
☐ Temporomandibular joint disorder (TMD)	☐ Chronic fatigue	☐ Fibromyalgia	☐ Chronic back pain	☐ Post-traumatic stress disorder (PTSD)

Please answer the following questions:

Do you have pain in your vulva/labia, clitoris, scrotum, testicles, penis or anus?	☐ Yes ☐ No
Do you have numbness in the same area?	☐ Yes ☐ No
Is your pain worsened by sitting?	☐ Yes ☐ No
Is your pain worsened by your bladder being full?	☐ Yes ☐ No
Is your pain worsened by urination?	☐ Yes ☐ No
Does the pain wake you up at night?	☐ Yes ☐ No
Have you ever had a pudendal nerve block?	☐ Yes ☐ No
If yes, did it improve the pain (even for a few hours)?	☐ Yes ☐ No
Have you ever had any fall injuries (i.e. neck, back or tailbone)?	☐ Yes ☐ No
Have you ever had a motor vehicle accident?	☐ Yes ☐ No
Do you regularly ride a bicycle?	☐ Yes ☐ No
Have you had any significant weight loss (>20 pounds/year)?	☐ Yes ☐ No

Does your pain improve with bowel movements?	☐ Yes ☐ No
Does your pain get worse with bowel movements?	☐ Yes ☐ No
Are bowel movements painful?	☐ Yes ☐ No
Do you have any rectal bleeding or blood in your stool?	☐ Yes ☐ No
Do you have any of the following symptoms?	
Nausea	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No
Bloating	☐ Yes ☐ No
Constipation	☐ Yes ☐ No

Surgical History

Procedure		Date (year)	Surgeon
Cystoscopy (looking inside the bladder)	☐ Yes ☐ No		
Hysterectomy (removal of the uterus)	☐ Yes ☐ No		
Myomectomy	☐ Yes ☐ No		
Endoscopy	☐ Yes ☐ No		
Colonoscopy	☐ Yes ☐ No		
Ovarian cyst removal	☐ Yes ☐ No		
C-section	☐ Yes ☐ No		
Appendectomy (appendix removal)	☐ Yes ☐ No		
Prostatectomy (prostate removal)	☐ Yes ☐ No		
Colectomy (colon removal)	☐ Yes ☐ No		
Vasectomy	☐ Yes ☐ No		
Spine surgery	☐ Yes ☐ No		

Medications (have you used any of the following? Please answer below):

Medication		Dose (if you know)	Helpful for pain?
Gabapentin (Neurontin)	☐ Yes ☐ No		☐ Yes ☐ No
Pregabalin (Lyrica)	☐ Yes ☐ No		☐ Yes ☐ No
Amitriptyline (Elavil)	☐ Yes ☐ No		☐ Yes ☐ No
Nortriptyline (Pamelor)	☐ Yes ☐ No		☐ Yes ☐ No
Muscle relaxant	☐ Yes ☐ No		☐ Yes ☐ No
Opioid	☐ Yes ☐ No		☐ Yes ☐ No
Duloxetine (Cymbalta)	☐ Yes ☐ No		☐ Yes ☐ No
Valium or baclofen suppository	☐ Yes ☐ No		☐ Yes ☐ No
Topical compounded cream	☐ Yes ☐ No		☐ Yes ☐ No

Menstrual History ***(complete only if you were assigned FEMALE at birth – if not, skip to next page)***

If you DO NOT menstruate, select the reason(s) why:

☐ Hysterectomy ☐ Menopause ☐ Birth control ☐ Other:

Date of your last menstrual period: _____

If you currently menstruate, do you have any of these symptoms during your period?

☐ Heavy bleeding ☐ Severe pain ☐ Irregular bleeding (>once a month) ☐ Bleeding > 7 days/month ☐ Mood swings

☐ Fatigue ☐ Breast tenderness ☐ Constipation ☐ Diarrhea ☐ Headaches

If you have painful periods, how long have you had this type of pain? _____

Do you CURRENTLY regularly (>3 times a month) miss school or work due to your painful period?

☐ Yes ☐ No

If you have painful periods, have you used any of the following to help with your pain during your period? (Check all that apply)

☐ Birth control pill ☐ Vaginal ring ☐ Depoprovera injection ☐ IUD ☐ NSAIDs (advil, aleve)

☐ Tylenol ☐ Other:

What are you using for birth control/ contraception? (Check all that apply)

☐ Nothing ☐ Condoms ☐ Birth control pill ☐ Depoprovera injection ☐ Nexplanon implant

☐ IUD ☐ Vaginal ring ☐ Tubal ligation ☐ Other:

Pregnancy/Obstetric History

Have you ever been pregnant? ☐ Yes ☐ No

Have you ever had a vaginal delivery? ☐ Yes ☐ No

Have you ever had a C-section? ☐ Yes ☐ No

Were there any complications during delivery?

☐ Grade 3 or 4 laceration ☐ Vacuum/forceps use ☐ Wound complication ☐ Other:

Sexual history

Are you currently sexually active? ☐ Yes ☐ No

Is your pain worse DURING sexual activity? ☐ Yes ☐ No

Is your pain worse DURING orgasm or ejaculation? ☐ Yes ☐ No

Is your pain worse AFTER sexual activity? ☐ Yes ☐ No

Do you avoid sexual activity because of pain? ☐ Yes ☐ No

Sexual transmitted infection history

Have you ever had a sexually transmitted infection (STI)? *Check ALL the apply*:

☐ Herpes ☐ Chlamydia ☐ Hepatitis ☐ Gonorrhea
☐ Syphilis ☐ HIV ☐ HSV ☐ Pelvic inflammatory disease

Pain History and Description

When did your pain begin? Month: Year: ☐ I don't know

Please describe your pain:

How did your main pain begin? Do you recall a specific incident that occurred? (check one):

☐ Injury at home ☐ Injury at work ☐ Motor vehicle crash ☐ After surgery ☐ Cancer

☐ After infection ☐ After childbirth ☐ No obvious cause

How did your pain begin? ☐ Suddenly OR ☐ Gradually

Since your pain began, is your pain (*check only one*):

☐ No different ☐ Getting better ☐ Getting worse ☐ I don't know

Which statement best describes your pain (*check only one*):

☐ Always present (at the same intensity)
☐ Always present (level of pain varies)
☐ Often present (pain free for periods <6 hours)
☐ Occasionally present (pain once to several times per day lasting up to an hour)
☐ Rarely present (pain occurs every few days or weeks)

How would you describe your pain (*check all that apply*)?

☐ Sharp, stabbing ☐ Crampy ☐ Heavy feeling in the pelvis ☐ Dull, achy
☐ Pulling, tugging ☐ Throbbing ☐ Burning ☐ Falling out sensation
☐ Other:

Does your pain ever wake you up from sleep? ☐ Yes ☐ No
Does your pain ever spread to other regions of your body? ☐ Yes ☐ No

What makes your pain WORSE? (*check all that apply*):

☐ Walking ☐ Climbing stairs ☐ Heavy lifting ☐ Sitting ☐ Getting in/out of car
☐ Urination ☐ Full bladder ☐ Menstrual period ☐ Bowel movement ☐ Sexual contact
☐ Weather ☐ Exercise ☐ Contact with clothing ☐ Stress ☐ Housework

What makes your pain BETTER? (*check all that apply*):

☐ Lying down ☐ Ice/heat ☐ Massage ☐ Exercise ☐ Being distracted
☐ Urination ☐ Bowel movement ☐ Laxatives ☐ Hot bath ☐ Pain medication
☐ Medication ☐ It goes away by itself ☐ When stress is low ☐ Nothing makes it better

Please mark <u>ALL</u> area where you have pain on the Body Maps below as they apply to you. Please shade or circle each area of pain.