Pelvic Pain Questionnaire for Girls and Women

Pelvic Pain Foundation OF AUSTRALIA

Thank you for completing this questionnaire. It includes questions about you, your pain, your medical history and your family history.

For some of the questions you will be asked how bad your pain is on a scale from 0-10.
A score of 0 would mean no pain at all, and 10 would be the worst pain you can imagine.

Other questions ask you to circle the answer that describes your pain best.

If your problems vary from month to month, think about how they might affect you on a typical month over the last 3 months.

You will find information on pelvic pain for you and your family at www.pelvicpain.org.au

Firstly, please describe the problem that worries you most

_____
_____
_____
_____
_____

You and your pain

1. Your age _____

2. How many days over an average month would you have pelvic pain or discomfort of *any* kind, even mild pain? (number 1-30)_____

3. How many days over an average month would you be *entirely* well with no pelvic discomfort at all? (number 1-30)_____

(Please note that the answer to Q 2 and Q 3 should add up to 30)

Your Operations

4. Please list any operations you have had and the year they were done.

_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____
_____Year_____

If you have any operation records, please bring these with you to your appointment.

Your Medications

5. Are you currently using any medications, including over-the-counter or complementary medicines?

Medications I use with periods

_____

_____

Medications I use every day

_____

_____

Medications I use occasionally

_____

_____

6. Do you have any allergies? _____

Your Periods

7. How old were you when your periods started? _____

8. When was the first day of your last period? _____

9. How long between the first day of one period and first day of your next period? _____

10. How heavy is the bleeding? ☐ Light ☐ Medium ☐ Heavy ☐ Variable

11. Are you currently using any of these hormonal medications?

Implanon ☐ Yes ☐ No

Mirena IUCD ☐ Yes ☐ No (name of pill) _____

Oral contraceptive pill ☐ Yes ☐ No (name)_____

Other ☐

No, I don't use any hormonal preparations ☐

Period Pain

12. Do you have period pain? ☐ Yes ☐ No ☐ Occasionally Pain Score (0-10)_____

If so, how old were you when your periods became painful? _____

How many days each month do you have period pain for? _____

If you now have pain of some kind on most days, when did it change from pain just with periods, to pain on most days? _____

Where do you feel your period pain?

☐ Low abdomen at the front ☐ Lower back ☐ Left side lower abdomen

☐ Right side lower abdomen ☐ Front of the legs ☐ Back of the legs

☐ Foot ☐ Anal area ☐ Other

Does the contraceptive pill help your period pain?

☐ Yes, a lot ☐ a little ☐ not at all ☐ I have never tried the pill

Do period pain medications (ibuprofen, Ponstan, Naprogesic etc) help your period pain?

☐ Yes, a lot ☐ a little ☐ not at all ☐ I have never tried these medications

Stabbing or sudden pains

13. Do you have sudden or stabbing pains in the pelvis or abdomen?

☐ Yes ☐ No ☐ Occasionally Pain score (0-10) _____

If so, When did these pains start? _____

Where do you feel these pains?

☐ Low abdomen at the front ☐ Lower back
☐ Left side lower abdomen ☐ Right side lower abdomen
☐ Front of the legs ☐ Back of the legs ☐ Foot ☐ Anal area
Other _____

Do any exercises, movements or positions make these pains worse? Which ones?

_____

14. What exercise do you do?

_____

Your Bladder

15. Are you happy with your bladder function? Yes / No / Mostly

16. How many times do you pass urine each day?

During the day, while awake? _____
At night, after going to sleep? _____

17. *If you have bladder problems,*

When did these bladder problems start? _____
When you need to pass urine, can you wait until later, or do you need to go straight away? _____
Do you have bladder pain? ☐ Yes ☐ No ☐ Only when I try to 'hold on'
Do you have pain passing urine? ☐ Yes ☐ No ☐ Only when pain is severe
Are there times when you find it difficult to start passing urine? Yes / No
How much fluid do you drink each day? _____
Have you ever had a bladder infection? ☐ Yes ☐ No

Your Bowel

18. Do you have problems with your bowel? ☐ Yes ☐ No ☐ Occasionally

If so, How old were you when your bowel problems started? _____

Do you have constipation?	☐ Yes	☐ No	☐ Sometimes	☐ Only with periods
Do you have diarrhoea?	☐ Yes	☐ No	☐ Sometimes	☐ Only with periods
Do you feel bloated?	☐ Yes	☐ No	☐ Sometimes	☐ Only with periods
Do you have bowel pain?	☐ Yes	☐ No	☐ Occasionally	☐ Only with periods

Your Diet

19. Are there foods that don't suit you? ☐ Yes ☐ No

Wheat	☐ Yes	☐ No
Dairy foods	☐ Yes	☐ No
Fatty foods	☐ Yes	☐ No
Other foods	_____	

20. How would you describe your diet? _____

Headaches

21. Do you get headaches? ☐ Yes ☐ No ☐ Occasionally

If so, At what age did your headaches start? _____

Do you get headaches or migraines at period time? ☐ Yes ☐ No ☐ Occasionally
Pain Score _____

Do you get bad headaches or migraines at other times? ☐ Yes ☐ No ☐ Occasionally
Pain Score _____

Do you get milder background headaches at other times? ☐ Yes ☐ No ☐ Occasionally
Pain Score _____

22. Have you ever been diagnosed with migraines? ☐ Yes ☐ No

23. How many days a month do you have a headache, even a mild headache? _____

Your Vulva (The Vulva is the skin between your legs near the opening of the vagina)

24. Do you have vulval pain or soreness? ☐ Yes ☐ No Pain score (0-10) _____

If so, when would you get this pain? (circle as many as apply)

☐ Anytime ☐ with intercourse ☐ using tampons ☐ sitting

☐ only with a vaginal infection

Your General Wellbeing

25. Do you have any of the following symptoms?

Unusual tiredness or fatigue?	☐ Yes	☐ no	☐ only with periods
Poor sleep?	☐ Yes	☐ no	☐ only with periods
Unusual sweating?	☐ Yes	☐ no	☐ only with periods
Dizziness or feeling faint?	☐ Yes	☐ no	☐ only with periods
Anxiety?	☐ Yes	☐ no	☐ only with periods
Low mood?	☐ Yes	☐ no	☐ only with periods
Nausea	☐ Yes	☐ no	☐ only with periods

Your Sexual Wellbeing

26. Are you currently or have you ever been in a sexual relationship? ☐ Yes ☐ No

If so, Do you feel pain or discomfort during sexual activity? ☐ Yes ☐ No ☐ Occasionally
Pain score _____

Has intercourse always been painful? ☐ Yes ☐ No
If not, at what age did intercourse become painful? _____

Have there been distressing sexual events during your life that you would like to discuss further with us? ☐ Yes ☐ No

Pregnancy and Contraception

27. Have you ever been pregnant? ☐ Yes ☐ No

28. Do you have children?_____How many?_____

29. Are you currently trying to become pregnant?_____

If not, what type of contraception are you using?_____

30. When was your last smear test?_____Was it normal?_____

Your General Health

31. Do you smoke cigarettes? _____How many?_____

32. Do you have any of the following medical conditions?

Arthritis or an Auto-immune Disorder?	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Coeliac Disease	☐ Yes	☐ No
Ulcerative Colitis or Crohns Disease	☐ Yes	☐ No
Clots in the legs or lungs, or a blood clotting disorder	☐ Yes	☐ No

Other medical conditions? (Please list) _____

Your Family History

33. Does anyone in your family have any of the following medical conditions?

Long term pain condition	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Coeliac Disease, Ulcerative Colitis, Crohns Disease	☐ Yes	☐ No
Rheumatoid Arthritis or SLE	☐ Yes	☐ No
Cancer of any kind	☐ Yes	☐ No
Clots in the legs or lungs, or a blood clotting disorder	☐ Yes	☐ No

Thank you for completing this questionnaire.