Name:_____ Age:_____ M/F Date:_____

1. Describe your main problem:_____

_____

2. When did your problem first begin?_____months ago or_____years ago.

3. Was your first episode of the problem related to a specific incident? Yes No
If yes, please describe and specify date_____

_____

4. Since that time it is:___staying the same ___getting worse ___getting better

5. Rate the severity of this problem on a scale from 0-10 with 0 being no problem and 10 being an extreme problem___.

6. Rate your pain level regarding this problem on a scale of 0-10 with 0 being no pain and 10 being the worst pain___. Describe the nature of the pain (i.e. constant burning, intermittent ache)_____

7. Date of last Physical Exam_____Tests performed_____

_____

8. Describe previous treatment/exercises_____

_____

9. How has your lifestyle/quality of life been altered because of this problem?
Social activities (exclude physical activities), specify_____
Diet/Fluid intake, specify_____
Physical activity, specify_____
Work, specify_____
Other_____

10. Activities/ events that cause or aggravate your symptoms:_____

_____

11. What relieves your symptoms?_____

_____

12. What are your treatment goals and concerns?_____

_____

Since the onset of your current symptoms have you had: (check all boxes that apply)

- ❑ Fever/Chills
- ❑ Unexplained weight change
- ❑ Dizziness or fainting
- ❑ Change in bowel or bladder functions
- ❑ Other_____
- ❑ Malaise (unexplained tiredness)
- ❑ Unexplained muscle weakness
- ❑ Night pain/sweats
- ❑ Numbness/Tingling

General Health circle one: Excellent Good Average Fair Poor
Occupation:_____Hrs/wk___On disability or leave?_____Activity restrictions?____

Activity/Exercise circle one**:** None 1-2 days/week 3-4 days/week 5+ days/week
Describe_____

Mental Health: Current stress levels circle one: High Med Low Current psych therapy:___

Past Medical History: Please include surgeries_____
_____
Do you have a history of sexual abuse? Yes No
Do you have any sexually transmitted diseases? Yes No
Please describe and specify date_____

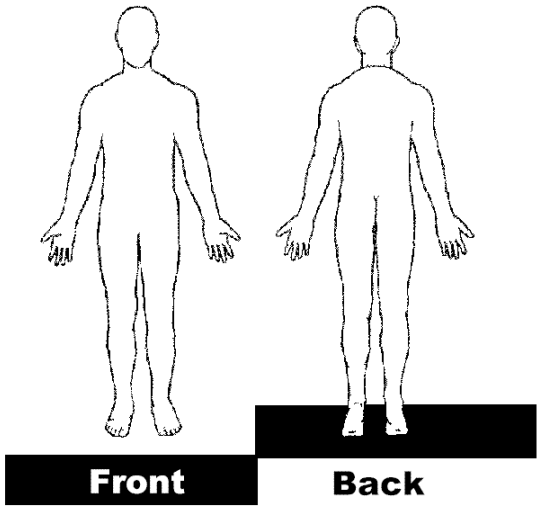
Ob/Gyn History (females only) check all that apply

❑ Childbirth vaginal deliveries	#_____	❑ Vaginal dryness
❑ Episiotomy	#_____	❑ Painful periods
❑ C-Section	#_____	❑ Menopause-when?_____
❑ Difficult childbirth	#_____	❑ Painful vaginal penetration
❑ Prolapse or organ falling out		❑ Pelvic Pain
❑ Other/describe		

Males Only

❑ Prostate disorders	❑ Erectile dysfunction
❑ Shy bladder	❑ Painful ejaculation
❑ Pelvic pain	❑ Other/describe

Medications-pills, patch	Start:	Reason for taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____



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

Is there anything else that you think would be helpful for your therapist to know about your condition?_____

Pelvic Symptom Questionnaire

Bladder/ Bowel habits/ Symptoms

Y/N Trouble initiating urine stream
Y/N Urinary intermittent/ slow stream
Y/N Strain or push to empty bladder
Y/N Difficulty stopping the urine stream
Y/N Trouble emptying bladder completely
Y/N Blood in urine
Y/N Dribbling after urination
Y/N Constant urine leakage
Y/N Trouble feeling bladder urge/ fullness
Y/N Recurrent bladder infections
Y/N Painful urination
Y/N Other/describe_____

Y/N Blood in stool/feces
Y/N Painful bowel movements (BM)
Y/N Trouble feeling bowel urge/ fullness
Y/N Seepage/ loss of BM without awareness
Y/N Trouble controlling bowel urge
Y/N Trouble holding back gas/ feces
Y/N Trouble emptying bowel completely
Y/N Need to support/ touch to complete BM
Y/N Staining of underwear after BM
Y/N Constipation/ straining____% of time
Y/N Current laxative use-type_____

Describe typical position for emptying_____

1. Frequency of urination: awake hours:_times per day, sleep hours:____times per night
2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet (check one)? ____minutes, ____hours, ____not at all.
3. The usual amount of urine passed is (check one):____small ____medium ____large
4. Frequency of bowel movements: ____times per day, ____ times per week, or_____.
5. Bowel movements typically are (check one): __watery, __loose, __formed, __pellets, __other
6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet (check one):____minutes, ____hours, ____not at all.
7. If constipation is present describe management techniques_____
8. Average fluid intake (one glass is 8oz or one cup)_____glasses per day.
9. Rate a feeling of organ "falling out"/ prolapse or pelvic heaviness/ pressure:

____None present
____Times/month (specify if related to menstrual period)
____With standing for____minutes or____hours
____With exertion or straining
____Other_____

10 a. Bladder leakage-number of episodes
__No leakage
__Times per day
__Times per week
__Times per month
__Only with physical exertion/cough

10b. Bowel leakage-number of episodes
__No leakage
__Times per day
__Times per week
__Times per month
__ Only with exertion/strong urge

11a. On average, how much urine do you leak?
__ No leakage
__ Just a few drops
__Wets underwear
__Wets outerwear
__Wets the floor

11b. How much stool do you lose?
__No leakage
__Stool staining
__Small amount in underwear
__Complete emptying
__Other_____

12. What form of protection do you wear? (Please check only one) __None __Minimal (tissue paper, panty shield) __Moderate (maxi pad) __Maximum (diaper) __Other_____

On average, how many pad/protection changes are required in 24 hours?_____#of pads

Vulvar Pain Functional Questionnaire (V-Q)

These are statements about how your pelvic pain affects your everyday life. Please check one box for each item below, choosing the one that best describes your situation. Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment. Your response will be kept completely confidential at all times.

1. Because of my pelvic pain:

- ❑ 3 I can't wear tight-fitting clothing like pantyhose that put any pressure over my painful area.
- ❑ 2 I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area
- ❑ 1 I can wear whatever I like most of the time, but every now ath then I feel pelvic pain caused by pressure from my clothing.
- ❑ 0 I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain:

- ❑ 3 Gets worse when I walk, so I can only walk fare enough to move around in my house, no further.
- ❑ 2 Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.
- ❑ 1 Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.
- ❑ 0 My pain does not get worse with walking; I can walk as far as I want to
- ❑ 0 I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain:

- ❑ 3 Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.
- ❑ 2 Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.
- ❑ 1 Occasionally gets worse when I sit, but most of the time sitting is comfortable.
- ❑ 0 My pain does not get worse with sitting. I can sit as long as I want to.
- ❑ 0 I have trouble sitting for very long because of another medical problem, but pelvic pain does not make it hard to sit.

4. Because of pain pills I take for my pelvic pain:

- ❑ 3 I am sleepy and I have trouble concentrating at work or while I do housework.
- ❑ 2 I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.
- ❑ 1 I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
- ❑ 0 I don't have any problems with the pills I take for pelvic pain.
- ❑ 0 I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain:

- ❑ 3 I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.
- ❑ 2 It hurts when I try to have a bowel movement, but the pain goes away when I am finished.
- ❑ 1 Most of the time it does not hurt when I have a bowel movement, but every now and then it does.
- ❑ 0 It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain:

❑ 3 I don't get together with my friends or go out to parties or events.
❑ 2 I only get together with my friends or go out to parties or events now and then.
❑ 1 I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.
❑ 0 I get together with friends or go to events whenever I want, pelvic pain does not get in the way.

7. Because of my pelvic pain:

❑ 3 I can't stand for the doctor to insert the speculum when I go to the gynecologist.
❑ 2 I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.
❑ 1 It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.
❑ 0 it never hurts for the doctor to insert the speculum when I go to the gynecologist.

8. Because of my pelvic pain:

❑ 3 I can't use tampons at all, because they make my pain much worse.
❑ 2 I can only use tampons if I put them in very carefully.
❑ 1 It usually doesn't hurt to use tampons, but occasionally it does hurt.
❑ 0 It never hurts to use tampons.
❑ 0 This question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.

9. Because of my pelvic pain:

❑ 3 I can't let my partner put a finger or penis in my vagina during sex at all.
❑ 2 My partner can put a finger or penis in my vagina very carefully, but it still hurts.
❑ 1 It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.
❑ 0 This question does not apply to me because I don't have a sexual partner
❑ 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

10. Because of my pelvic pain:

❑ 3 It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.
❑ 2 My partner can touch me sexually outside of the vagina if we are very careful
❑ 1 It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every now and then it does hurt.
❑ 0 It never hurts for my partner to touch me sexually outside of the vagina
❑ 0 This question does not apply to me because I don't have a sexual partner
❑ 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

11. Because of my pelvic pain:

❑ 3 It is too painful to touch myself for sexual pleasure.
❑ 2 I can touch myself for sexual pleasure if I am very careful.
❑ 1 It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.
❑ 0 It never hurts to touch myself for sexual pleasure.
❑ 0 I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.