Thankyou for taking the time to fill in these forms.

Many of the girls and women who come to see us have quite complicated pain. Others have just one thing that bothers them. We hope to make a real difference to your pain, and the information on these sheets helps us a lot. It also means that we have more time with you to discuss the problems that bother *you* most.

For some of the questions we have asked you to tell us how bad your pain is on a scale from 0 to 10. A score of 0 would mean no pain, and a score of 10 would be the worst pain you could imagine.

Firstly, what is the problem that bothers *you* the most?

____

____

____

____

____

Your age _______________

How many days each month do you have *any* pain or discomfort at all? _______________

How many days each month are you *entirely well* with no discomfort at all? _____________

If you have pain on most days, how old were you when your pain changed from pain with periods to pain of some kind on most days? ____

Pain with periods?

Are your periods painful? (please circle correct answer) Yes / No / Always / Sometimes
If your periods are painful,

Pain score (0-10) is _______________
How old were you when your periods became painful? _____________________________
For how many days each month do you have period pain? __________________________
Where do you feel your period pain? ____

Does the contraceptive pill help your period pain? Yes, a lot / a little / not at all
Do period pain medications help your pain? Yes, a lot / a little / not at all
Which medications or treatments do you use for period pain?
Have you ever been diagnosed with endometriosis? Yes / No At what age? _________

More information about your periods

How old were you when your periods started? ____
How many days do you bleed with each period? ____
How long between the first day of one period and the first day of the next period? _____________

How heavy is the bleeding? ____
How many pads or tampons would you use on a heavy day? ________________________________
What date did your last period start? ____
Do you bleed between periods? ____
Are you on the contraceptive pill or a Mirena IUCD_______________________________________

Bowel problems?

Are you happy with the way your bowel works? Yes / No / mostly

If you have bowel problems,

Do you have bowel pain? Yes / NO / Only with periods

Pain score (0-10) _____

Do you have pain opening your bowels? Yes / No / Only with periods / all the time

How old were you when your bowel problems started? ______________________________

Do you have constipation? ________________________________

Do you have diarrhoea? ___________________________________

Do you feel bloated? _____________________________________

Are there foods that don't suit you, or food allergies?_______________________________

How would you describe your diet?____

Bladder problems?

Are you happy with the way your bladder works? Yes / No / mostly

If you have bladder problems,

Do you have bladder pain? Yes / No / Occasionally / Only when I try to 'hold on'

Pain score (0-10) _____________

At what age did your bladder problems start?______________________________________

How many times do you usually pass urine during the day? _________________________

At night, after getting into bed? ___________________

Can you 'hold on' or do you need to go to the toilet straight away? ___________________

Are there any times when you find it difficult to start passing urine? __________________

How much fluid do you drink each day? __________________________________

What type of fluids do you drink? ____

Pain with intercourse?

Do you have pain with intercourse? Yes / No / occasionally Pain score (0-10) __________

If you have pain with intercourse,

Has intercourse always been painful? ____________________________________

At what age did intercourse become painful? _____________________________________

Are you able to use tampons comfortably? ________________________________

Are there any other sexual problems that you would like to discuss? __________________

Pain on one side, or both sides?

Do you have pain on one side that is different to your period pain? Yes / No / Occasionally

If so,

Pain score (0-10) ______

How old were you when these pains started? _____________________________________

Where do you feel this pain? ____

What sort of activities make this pain worse? ___________________________________

What helps this pain? ____

How many times a month do you get this pain?

Pain with movement or exercise?

Do you have pain with movement or exercise? Yes / No / Occasionally
If so,

What type of activity can cause you pain? ________________________________
Do you have pain when sitting? Yes / No / Occasionally
What type of exercise do you do? ____
Has pain prevented you exercising? Yes / No / Occasionally / most days / every day

Headaches?

Do you get headaches? Yes / No / Occasionally / With each period
If so,

Pain score (0-10) ________
What age did your headaches start?_______________________________________
How many days a month do you have a headache of any kind? ________________
Where do you feel your headaches? __________________________________
Do you, or anyone in your family have migraines? __________________________

Problems with tiredness, fatigue or poor sleep?

Do you have problems with tiredness or fatigue? Yes / No
If so,

What age were you when you when the tiredness started? __________________________

Do you have trouble sleeping? Yes / No / only at period time / most nights / every night
If so,

When did this problem start? ____

Does pain wake you at night? No / Only at period time / occasionally / most nights / every night
If so,

Which of your pains is most likely to wake you? __________________________________

The things that concern you the most

What worries you most about your pain? Is there something in particular that you fear?

____

____

Please list the operations you have had and in what year these were done.

1.
____
2.
____
3.
____

Have you had any problems with operations or anaesthetics?

Do you have any medical conditions or illnesses?

____

Pregnancy:

Do you have children? ____________ How many?_________________________

Are you currently trying to become pregnant?_______________________________

What type of contraception are you using? _______________________________

Your medications

What medications, herbal therapies or complementary medications do you take?

____

Are you allergic to any medications? ____

Do you smoke cigarettes? ____________________How many? _______________________

When was your last smear test? __________________ Was it normal? Yes / No

Your family

Does anyone in your family have?

Endometriosis? ____

Gynaecological problems or cancers? ____________________________________

Diabetes, coeliac disease, SLE, Rheumatoid arthritis ________________________

Blood clots in the legs or lungs? ____

© www.pelvicpainsa.com.au